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DEPARTMENTS OF LABOR, HEALTH AND HUMAN SERVICES, EDUCATION AND RELATED AGENCIES APPROPRIATIONS FOR FISCAL YEAR 1990

HEARINGS

BEFORE A

SUBCOMMITTEE OF THE

COMMITTEE ON APPROPRIATIONS

UNITED STATES SENATE

ONE HUNDRED FIRST CONGRESS

FIRST SESSION

ON

H.R. 2990/H.R. 3566

AN ACT MAKING APPROPRIATIONS FOR THE DEPARTMENTS OF LABOR, HEALTH AND HUMAN SERVICES, AND EDUCATION, AND RELATED AGENCIES, FOR THE FISCAL YEAR ENDING SEPTEMBER 30, 1990, AND FOR OTHER PURPOSES

Part 3 (Pages 1-717)

Nondepartmental witnesses

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DEPARTMENTS OF LABOR, HEALTH AND HUMAN SERVICES, EDUCATION AND RELATED AGENCIES APPROPRIATIONS FOR FISCAL YEAR 1990

WEDNESDAY, MAY 3, 1989

U.S. SENATE,
SUBCOMMITTEE OF THE COMMITTEE ON APPROPRIATIONS,
Washington, DC.

The subcommittee met at 9 a.m., in room SD-192, Dirksen Senate Office Building, Hon. Daniel K. Inouye presiding.

Present: Senators Inouye and Adams.

CONGRESSIONAL WITNESSES

Senator INOUYE. The subcommittee will please come to order.

By authority of the chairman of this committee, Senator Harkin, I have been requested to chair the hearing this morning, and this morning will begin the first of 6 days of public witness testimony focusing on programs funded by the Subcommittee on Labor, Health and Human Services.

During the several sessions, the subcommittee will hear testimony from approximately 150 witnesses, and we will begin this morning with five Senators, followed by a group of public witnesses from throughout the United States.

It is a matter of great regret to all the members of the subcommittee that we have had to limit the number of witnesses we are able to hear this year. You have all been very understanding about our time constraints, and I do want to assure you that witnesses who have their testimony submitted by the close of business on May 15 will have their full testimony made part of the hearing record.

In other words, the record will be kept open until then.

As you know, based upon the letter all of you received from Chairman Harkin, each witness has been requested to limit his or her oral testimony to 3 minutes.

However, I will not use this gadget in front of me, but out of courtesy to all of those who want to testify this morning, I hope that you will be brief.

This will give us some time for questions or discussion.

STATEMENT OF HON. J. JAMES EXON, U.S. SENATOR FROM NEBRASKA

Senator INOUYE. Our first witness this morning is the senior Senator from the State of Nebraska, a very distinguished member of this body, and I am most pleased and honored to welcome him to this committee.

Welcome, sir.

Senator Exon. Mr. Chairman, thank you, sir, very much.

Just let me start out by saying that I am going to be brief, especially—it is tough on a U.S. Senator to be brief. When you limit us as you do, which you must——

Senator Inouye. That is the most difficult part of our task here.

Senator Exon. But I just want to start out by reading a fairly short statement by comparison, Mr. Chairman.

I just want to start out by thanking you and your subcommittee for the truly outstanding job that I think you have done over the years. Certainly you are going to be tested now with the constraints of the budget that are about to come on us. We are going to have to make some very tough decisions in this subcommittee, and the committee as a whole on other parts of the budget.

But I appreciate the opportunity, Mr. Chairman, to appear before your subcommittee this morning in support of a very, very important educational funding program, the Impact Aid Program that we have great discussions on each and every year.

We reauthorized the Impact Aid Program last year as part of H.R. 5, the Hawkins-Stafford Elementary and Secondary Schools Improvement Act. I worked closely with Chairman Pell drafting the impact aid portions of that bill. We crafted a very delicately balanced program that took into consideration the needs of all types of impact aid recipients. I think we were quite successful. The highly fragmented impact aid community rallied behind the Senate version of the bill, and we were able to push it through the conference committee with very few changes.

However, the success of that program hinges on full implementation of a rather intricate funding distribution formula. Full implementation of the distribution formula, and, therefore, success will not happen without full funding through the appropriations process.

For fiscal year 1989, Mr. Chairman, the program was authorized at $735 million. The actual appropriation was $708 million—$27 million short of the authorized spending level.

Mr. Chairman, due to this shortfall in appropriations, we have had to revisit the authorization bill and make some changes in the distribution of funds. If the program had been fully funded, we would not have had to readjust the formula, Mr. Chairman, we will continue to work with you and others in this regard. We cannot continually revisit this program, in order to correct the problems created by funding shortfalls.

For fiscal year 1990, the program is authorized at $785 million. I cannot stress enough the importance of this program.

Impact aid is not a nice, neat little "if we have enough money, we'll go ahead with it' program. Impact aid is a Federal obligation to school districts to compensate for lost tax dollars due to the presence of the Federal Government in that district.

The school districts depend on that money as a part of their operating budget. If they do not receive compensation for educating federally-connected children, many school districts will have no choice but to either refuse to educate these children, or start charging tuition for such children.

In fact, in 1970, one impact aid district in my State closed its doors, terminated one-half of its staff, and cut school programs. Nine other school districts across the Nation faced similar circumstances.

In 1973, a school district in South Dakota closed its doors due to lack of funds. In 1981, Fairfax County, VA, proposed charging tuition to students from Fort Belvoir. The list goes on.

Occurrences such as these will only increase in frequency and increase in severity if the program continues to be underfunded.

I lend my strong support and unwavering support to this program, and ask that this subcommittee do the same.

The program is vitally important to thousands of school districts across the Nation, serving a variety of students. If this is to be the era of strong educational emphasis, let it begin here, with full funding for the Impact Aid Program.

While I am here this morning, Mr. Chairman, I would like also just to put in a word of support for the State Student Incentive Grant Program, commonly referred to as SSIG.

As you may recall, last year's appropriations process seriously threatened this program. Mr. Chairman, I believe primarily through your concerns and your efforts, along with the action that I took, we were able to retain at least the 1987 funding level for this program, minus the 1.2-percent reduction applied to all discretionary programs.

I would hope that the program would fare better this year. We must recoup that 1.2 percent loss, plus at least an increase equal to inflation.

The SSIG program, as you know, requires a State match. Because of that match, students receive at least $2 for every Federal dollar appropriated. That is the best bargain we have in an area of student financial assistance.

I also urge the subcommittee's serious consideration and full support of this very important program.

Mr. Chairman, thank you very much for this opportunity to testify before your committee this morning, and I stand ready to be of further assistance to you in any way that we can in resolving these and other problems.

Senator **INOUYE**. Your wise words, sir, and especially your strong support, will mean much to this subcommittee, and I can assure you that impact aid is very important to all of us.

We look upon this as a matter of obligation, and we are well aware that many school districts depend upon it to such an extent that if it were cut off, it would mean cutting off education, as you have noted very eloquently.

I would say, if I could make any predictions, that we would restore all cuts, sir.

PREPARED STATEMENT

Senator **EXON**. Thank you, Mr. Chairman.

Those are encouraging words, and once again, I salute you for the leadership that you have shown over the years on the matter of education.

Senator **Inouye**. I thank you, sir.

Senator **Exon**. Thank you.

[The statement follows:]

Statement of Senator J. James Exon

Mr. Chairman, I appreciate the opportunity to appear before your subcommittee this morning in support of a very important education funding program, the impact aid Program.

We reauthorized the impact aid Program last year as part of H.R. 5, the Hawkins-Stafford Elementary and Secondary School Improvement Act. I worked closely with Chairman Pell drafting the impact aid portion of that bill. We crafted a very delicately balanced program that took into consideration the needs of all types of impact aid recipients.

I think we were quite successful. The highly-fragmented impact aid community rallied behind the Senate version of the bill and we were able to push it through the conference committee with very few changes.

However, the success of that program hinges on the full implementation of a rather intricate funding distribution formula. Full implementation of the distribution formula, and therefore success, will not happen without full funding through the appropriations process.

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Mr. Chairman, due to this shortfall in appropriations, we have had to revisit the authorizing bill and make some changes in the distribution of funds. If the program had been fully funded, we would not have had to readjust the formula. Mr. Chairman, we cannot continually "revisit" this program in order to correct the problems created by funding shortfalls.

For fiscal year 1990, the program is authorized at $785 million. I cannot stress enough the importance of this program. Impact Aid is not a nice neat little "if we have enough money" program. Impact Aid is a Federal obligation to school districts to compensate for lost tax dollars due to the presence of the Federal Government in that district. School districts depend on that money as part of their operating budget.

If they no not receive compensation for educating federally-connected children, many school districts will have no choice but to either refuse to reeducate these children or start charging tuition to such children. Mr. Chairman, I do not exaggerate. In 1970, one Impact Aid district in my State closed its doors, terminated one-half its staff, and cut school programs. Nine other school districts across the Nation faced similar circumstances.

In 1973, a school district in South Dakota closed its doors due to lack of funds. In 1981, Fairfax County, VA, proposed charging tuition to students from Fort Belvoir. The list goes on. Occurrences such as these will only increase in frequency and increase in severity if the program continues to be underfunded.

I lend my strong and unwaivering support to this program and ask that the subcommittee do the same. This program is vitally important to thousands of school districts across the Nation serving a variety of students. If this is to be the era of strong educational emphasis, let it begin here, with full funding for the Impact Aid Program.

While I am here this morning, Mr. Chairman, I would like to also put in a word of support for the State Student Incentive Grant (SSIG) program. As you may recall, last years appropriations process seriously threatened this program. I believe through your concerns, Mr. Chairman, and through action on my part, we were able to retain at least the 1987 funding level for this program, minus the 1.2 percent reduction applied to all discretionary program.

I would hope that the program will fare better this year. We must recoup that 1.2 percent loss plus at least an increase equal to inflation. The SSIG program, as you well know, requires a State match. Because of that match, students receive at least two dollars for every Federal dollar appropriated. That is the best bargain we have in the area of student financial assistance. I also urge the subcommittee's serious consideration and full support of this very important program.

Thank you Mr. Chairman, for the opportunity to testify here this morning.

STATEMENT OF HON. LARRY PRESSLER, U.S. SENATOR FROM SOUTH DAKOTA

Senator **Inouye**. Our next witness is a very distinguished member of the South Dakota delegation. If I may, may I call upon Senator Pressler.

Senator **Pressler**. Thank you very much, Mr. Chairman, and I shall summarize my testimony. I ask unanimous consent that you would place the entire part of it into the record.

Senator **Inouye**. You may be assured of that, sir.

Senator **Pressler**. Mr. Chairman, I thank you for this opportunity to testify before the Education Subcommittee for Appropriations, on behalf of the 39 South Dakota school districts which rely heavily on impact aid funding.

Over 10,000 category A and category B students in South Dakota depend on impact aid assistance to provide a firm foundation for their educational opportunities.

South Dakota has a particularly large number of schools located on or near Indian reservations, and I know the chairman has visited Shannon County School District at one point. I thank him very much for his visit to our State there.

Shannon County School District, on the Pine Ridge Indian Reservation, is located essentially on nontaxable Indian land. Approximately 85 percent of the student population from the entire reservation live in the school district, and these students are dependent upon the schools for a free public education for all students from preschool to age 21.

These schools are the means for both the State of South Dakota and the U.S. Government to meet their educational obligations to the Indian people.

However, State and Federal budget reductions have undercut the school's ability to offer an education program that actually prepares Indian students to succeed in modern society. Unemployment rates on South Dakota Indian reservations can be as high as or higher than 80 percent.

I think we all agree that the only true hope of the Indian people to break the chains of severe poverty is education. Impact aid is a significant contributing factor to the schools' ability to promote the economic and intellectual achievement of the Indian people.

Another example of a district that depends heavily on impact aid assistance is the Douglas School System, located on Ellsworth Air Force Base near Rapid City, SD.

Approximately 75 percent of the children educated in the Douglas School System are military dependents. More than 50 percent of this school system's budget comes from Federal aid. The Federal ownership of property in the district severely reduces local property tax revenues for school purposes.

Federal activities cause an influx of persons into this community, resulting in an increased number of children to be educated. Public Laws 81-874 and 81-815 recognize the basic responsibility of the Federal Government to compensate for lost revenue resulting from Federal activity or ownership.

Another concern of mine is funding for school construction under Public Law 81-815. It is imperative that the school construction program be fully funded. The Department of Education has many more school applicants awaiting funds than funds available for construction.

Last year, I successfully sponsored an amendment to the Hawkins-Stafford Elementary and Secondary School Improvement Amendments that initiated a thorough study of the need for financial assistance for school construction. This study should provide Congress with the proper information for any necessary redirection of the school construction program.

In conclusion, it is my earnest hope that Congress will recognize the extreme dependence of many school systems on impact aid, particularly our Indian schools. Loss of impact aid would be devastating to those school districts that have no other revenue.

Congress should appropriate the full $785 million in funding authorized for this program. Our Nation cannot move forward without a well educated citizenry to lead the way.

Senator INOUYE. Senator Pressler, as chairman of the Indian Affairs Committee, may I thank you for your very sensitive concern over the plight of native American Indians.

Your statement is, as always, very correct. The unemployment in your State among Indians is one of the most devastating, and the dropout rate for Indian students is one that should concern all of us.

You may be assured of our support.

STATEMENT OF HON. SPARK MATSUNAGA, U.S. SENATOR FROM HAWAII

Senator INOUYE. Now, I am pleased to call upon my colleague from the State of Hawaii, the Hon. Spark Matsunaga.

Senator MATSUNAGA. Thank you, Mr. Chairman.

I commend you for holding this hearing on Federal programs designed to assist native Hawaiians and others in the State of Hawaii and throughout the Nation.

I greatly appreciate being invited to testify here this morning.

As a cosponsor with you, Mr. Chairman, in many years of legislative effort to improve the education and health of native Hawaiians, I was extremely pleased when the 100th Congress took favorable action on our authorizing bills, and I now come before the committee to strongly support funding of the new programs in fiscal year 1990.

Native Hawaiians, a proud and hard-working people, were deprived of their sovereignty in 1893 when the government of Queen Liluokalani was overthrown by a band of foreigners. To a large extent, they also lost their cultural heritage, becoming a dispossessed minority in their own land.

For many years now, Federal and State studies have revealed that native Hawaiians are on the bottom rung of all the social indices. Native Hawaiian children constitute a majority in some of our schools, yet they have a very high dropout rate. They frequently fail to pursue higher education, and their unemployment rate is higher than that of the general population in Hawaii.

The teenage pregnancy rate in the native Hawaiian community is higher than average. And so is the infant mortality rate.

Native Hawaiians also suffer from disproportionately high incidence of cancer, diabetes, and hypertension, and are likely to die 10 years earlier than those in other racial and ethnic groups in the State of Hawaii.

A remedy for these problems is long overdue. While this solution may be expensive, I believe that it would be much more costly to ignore the education and health care needs of native Hawaiians.

One of the most attractive features of the legislation enacted last year is that it does not establish just another Federal bureaucracy to address the needs of yet another economically deprived minority group. Instead, it provides native Hawaiians with a means to design solutions to their health and education problems with the advice, cooperation, and financial aid of the Federal Government.

We know, for example, that early childhood education is a good thing for children from economically depressed regions of the country, or minority populations. Our understanding of this can be traced to the New Deal, and, in more recent times, to the Head Start program.

But, for the first time, the Native Hawaiian Education Act envisions an early childhood education program designed specifically to meet the needs of native Hawaiian children and their families.

By the same token, we know that preventive health care and good nutrition can extend lives and improve the quality of life. For the first time, legislation to improve the health status of native Hawaiians would enable Hawaiians themselves to attack their own unique health problems.

In short, the legislation enacted by the 100th Congress returns to native Hawaiians a measure of sovereignty and control over their own lives.

Passage of the new authorization laws is only one-half the battle, however. Congress must provide an adequate amount of funding for these new programs, and that is why I join with the other witnesses today to urge this subcommittee to include adequate funding for native Hawaiian education and health care in the fiscal year 1990 appropriation bill.

Finally, Mr. Chairman, in my capacity as chairman of the Subcommittee on Aging of the Senate Labor and Human Resources Committee, I would like to comment on another area of interest to native Hawaiians and other native Americans.

In 1984, Congress amended the Older Americans Act to establish a special program for American Indians and Alaskan Natives. Title VI of the act was intended to provide for native Americans programs such as nutrition services, transportation, and preventive health services—comparable to those provided under title III by senior centers and area agencies on aging throughout the country.

In 1987, we amended the act again to include native Hawaiians within the definition of native Americans who are eligible for services under title VI. Regretfully, although Congress acknowledged the pressing needs of elderly native Americans, and authorized increasing funds for each fiscal year, appropriations for title VI have remained static since 1984.

Although 136 Indian tribes currently are receiving funds under title VI, the native American population remains woefully underserved, and native Hawaiians are unable to receive any funds, unless the title VI appropriation is increased.

This year, there is another factor to consider. The Administration on Aging has announced that it will award grants to more than 50 additional tribes. Since additional funds have not been provided, this means that existing tribal programs will be drastically reduced or even abolished.

In many cases, this will leave elderly Indians without access to the nutritional programs authorized under the Older Americans Act.

This constitutes a dire emergency, and I was pleased when a modest increase in appropriations was included in H.R. 2072, the so-called dire emergency supplemental appropriations bill for fiscal year 1989 by the House Appropriations Committee.

The House committee reprogrammed $3.3 million to fund the additional Administration on Aging grants without reducing or eliminating existing title VI programs. Since this increase would trigger the native Hawaiian provisions, the committee reprogrammed additional funds earmarked for native Hawaiians.

While the fate of H.R. 2072 is now in some doubt, I am hopeful that the increased funds for title VI will be retained, inasmuch as they are reprogrammed funds and not new spending.

I would urge this subcommittee to support the emergency supplemental appropriations, which will primarily benefit Indian tribes. I also urge that increased funding be provided in the fiscal year 1990 appropriations bill.

The Older Americans Act Amendment of 1987 authorized $19.1 million for fiscal year 1990, which includes $1.4 million for elderly native Hawaiians. I anticipate that a request for $17 million will be submitted, and I hope that your committee will be able to support something close to that figure.

While the native Hawaiian population is relatively youthful, the number of Hawaiians over the age of 60 is increasing just as the number of senior citizens in the rest of the population is increasing. Over one-third of all elderly Hawaiians live in poverty, and the programs which have benefitted so many older Americans since 1965 would be of substantial assistance to them.

Again, Mr. Chairman, mahalo nui loa [thank you very much] for granting me the opportunity to testify during the subcommittee's Hawaii Day.

On another matter, Mr. Chairman, I support strongly the budget request of the U.S. Institute of Peace, and I ask unanimous consent that my statement in support of the Institute's request be included in the hearing record at the appropriate place.

Senator INOUYE. Without objection, so ordered.

Senator MATSUNAGA. Thank you again.

Senator INOUYE. As my colleague is well aware, in the last fiscal year, although the administration did not look favorably upon the Native Hawaiian Education Act, this Congress did appropriate nearly $5 million.

This year, once again the administration has come forth with a request for zero dollars, and I am certain that we will do something about that.

Senator MATSUNAGA. Thank you. Thank you very much.

Senator **INOUYE**. Your concern for native American Indians, especially the elderly, is well taken, and I am certain that this subcommittee will look upon that very favorably.

Senator **MATSUNAGA**. Thank you very much.

Senator **INOUYE**. Thank you very much.

PREPARED STATEMENT

Senator **MATSUNAGA**. I note that we have quite a few witnesses who have traveled all the way from Hawaii to testify before the subcommittee, so I will not take any more time.

Thank you again.

Senator **INOUYE**. Thank you.

[The statement follows:]

STATEMENT OF SENATOR SPARK MATSUNAGA

NATIVE HAWAIIANS

Mr. Chairman, I commend you for holding this hearing on Federal programs designed to assist native Hawaiians and others in the State of Hawaii, and I greatly appreciate being invited to testify.

As a cosponsor, with you, in many years of legislative effort to improve the education and health of native Hawaiians, I was extremely pleased when the 100th Congress took favorable action on our authorizing bills, and I now strongly support funding of the new programs in fiscal year 1990.

Native Hawaiians, a proud and hardworking people, were deprived of their sovereignty in 1893 when the government of Queen Liliuokalani was overthrown by a band of foreigners. To a large extent, they also lost their cultural heritage, becoming a dispossessed minority in their own land. For many years now, Federal and State studies have revealed that native Hawaiians are on the bottom rung of all the social indices. Native Hawaiian children constitute a majority of some of our schools, yet they have a very high drop-out rate, they frequently fail to pursue higher education, and their unemployment rate is higher than that of the general population in Hawaii. The teenage pregnancy rate in the native Hawaiian community is higher than average, and so is the infant mortality rate. Native Hawaiians also suffer from disproportionately high incidences of cancer, diabetes, and hypertension, and are likely to die ten years earlier than those in other racial and ethnic groups in the State of Hawaii. A remedy for these problems is long overdue, and while the solution may be expensive, I believe that it would be much more costly to ignore the education and health care needs of native Hawaiians.

One of the most attractive features of the legislation enacted last year is that it does not establish just another Federal bureaucracy to address the needs of yet another economically deprived minority group. Instead, it provides native Hawaiians with a means to design solutions to their health and education problems with the advice, cooperation and financial aid of the Federal Government. We know, for example, that early childhood education is a good thing for children from economically depressed regions of the country of minority populations. Our understanding of this can be traced to the New Deal and, in more recent times, to the Head Start program. But, for the first time, the Native Hawaiian Education Act envisons an early childhood education program designed specifically to meet the needs of native Hawaiian children and their families. By the same token, we know that preventive health care and good nutrition can extend lives and improve the quality of life. For the first time, legislation to improve the health status of native Hawaiians would enable Hawaiians themselves to attack their own unique health problems. In short, the legislation enacted by the 100th Congress returns to native Hawaiians a measure of sovereignty and control over their own lives. Passage of the new authorization laws is only half the battle, however. Congress must provide an adequate amount of funding for these new programs, and that is why I join with the other witnesses today to urge this Subcommittee to include adequate funding for Native Hawaiian Education and Health Care in the fiscal year 1990 appropriations bill.

Finally, Mr. Chairman, in my capacity as Chairman of the Subcommittee on Aging of the Senate Labor and Human Resources Committee, I would like to comment on another area of interest to native Hawaiians and other native Americans. In 1984, Congress amended the Older Americans Act to establish a special program for American Indians and Alaskan natives. Title VI of the Act was intended to provide for native Americans programs such as nutrition services, transportation and preventive health services comparable to those provided under Title III by senior centers and area agencies on aging throughout the country. In 1987, we amended the Act again to include native Hawaiians within the meaning of native Americans who are eligible for services under Title VI.

Regretfully, although Congress acknowledged the pressing needs of elderly native Americans and authorized increasing funds for each fiscal year, appropriations for Title VI have remained static since 1984. Although 136 Indian Tribes currently are receiving funds under Title VI, the native American population remains woefully underserved, and native Hawaiians are unable to receive any funds unless the Title VI appropriation is increased.

This year, there is another factor to consider. The Administration on Aging has announced that it will award grants to more than 50 additional tribes. Since additional funds have not been provided, this means that existing tribal programs will be drastically reduced or even abolished. In many cases, this will leave elderly Indians without access to the nutritional programs authorized under the Older Americans Act. This constitutes a dire emergency and I was pleased when a modest increase in appropriations was included in H.R. 2072, the "Dire Emergency Supplemental Appropriations" bill for fiscal year 1989 by the House Appropriations Committee. The House Committee reprogrammed $3.3 million to fund the additional Administration on Aging (AOA) grants without reducing or eliminating existing Title VI programs. Since this increase would trigger the native Hawaiian provisions, the Committee reprogrammed additional funds earmarked for native Hawaiians. While the fate of H.R. 2072 is now in some doubt, I am hopeful that the increased funds for Title VI will be retained, inasmuch as they are reprogrammed funds and not new spending.

I would urge this subcommittee to support the emergency supplemental appropriation which will primarily benefit Indian Tribes, and I also urge that increased funding be provided in the fiscal year 1990 appropriations bill. The Older Americans Act Amendments of 1987 authorizes $19.1 million for fiscal year 1990, which includes $1.4 million for elderly native Hawaiians. I anticipate that a request for $17 million will be submitted, and I hope that your Committee will be able to support something close to that amount. While the native Hawaiian population is relatively youthful, the number of Hawaiians over the age of 60 is increasing, just as the number of senior citizens in the rest of the population is increasing. Over one-third of all elderly Hawaiians live in poverty, and the meals programs which have benefited so many Older Americans since 1965 would be of substantial assistance to them.

Again, Mr. Chairman, "mahalo nui loa" (thank you very much) for granting me this opportunity to testify during the subcommittee's "Hawaii Day."

U.S. INSTITUTE OF PEACE

Mr. Chairman, as the principal Senate sponsor of the legislation which established the United States Institute of Peace in 1984, I greatly appreciate having this opportunity to testify in support of the Institute's fiscal year 1989 budget request.

In the three years since the Peace Institute actually became an operating entity (in February 1986), we have seen the establishment of all of the Institute's major program elements. First, as required by law, the Institute established a grants program so that one-quarter of its annual appropriation could be channelled to other institutions, organizations and individuals to strengthen peace education, research and training throughout the Nation. An in-house research program was established at the same time. Second, the Institute established the Jennings Randolph Program for International Peace, offering fellowships to scholars and leaders from the United States and other countries for a period not to exceed two years for research, education and training under the aegis of the Peace Institute. The Institute plans to increase the number of participants in this program to 28 in fiscal year 1990. Third, in the past two years, the Institute has focused on its education, training and information programs, launching a highly successful high school essay contest, cooperating with the CloseUp Foundation to help train high school teachers in the field of peace education, producing a pilot program on summitry for televisions' Public Broadcasting System, publishing a news letter and establishing a speaker's bureau to reach interested organizations throughout the country. In fiscal year 1989, the Institute also established the Jeannette Rankin Library Program which will collect and disseminate information relating to peace and conflict resolution.

Those of us in the Senate who have long supported the Institute and its mission can take considerable pride in its achievements during the last three years. In fiscal year 1990, the Institute should be able to build on its promising beginning, expanding its library and public outreach programs. Moreover, the Institute plans to solicit grant applications to obtain research in areas of particular interest to it, to expand its aid to other institutions, and to start publishing and disseminating the books and papers resulting from its first three years of work. I believe that these plans justify the modest increase in funds which the Institute is requesting for fiscal year 1990. It is particularly gratifying to note that the Institute is becoming more visible and that other institutions and organizations are beginning to recognize the valuable contribution which it can make to our Nation in the area of peace research, education and training. I might add that the fruits of the Institute's research can be of help not only to Executive Branch agencies such as the State Department and Defense Department, but also to Congress, a co-equal branch of government with important constitutional responsibilities relating to peace and war. While the Peace Institute is prohibited from engaging in policymaking activities, I can envision it providing information to appropriate committees in the form of educational papers and briefings, or undertaking specific research projects that are in line with its mission.

Mr. Chairman, the Institute has never been fully funded. It started with an initial appropriation of $4 million. In 1987, it carried over $3.6 million of its original appropriation and received additional funding of $625,000. In fiscal year 1988, its appropriation remained stable at $4.3 million. An increase to $7 million was approved for fiscal year 1989. For the upcoming fiscal year, I, personally, believe that the Institute could use the full amount of its authorization—$10 million. However, I support the Institute's request for $9.4 million and hope that this subcommittee will approve that amount so that the Institute can continue to grow and perform its vital work.

Thank you very much.

STATEMENT OF HON. HOWARD M. METZENBAUM, U.S. SENATOR FROM OHIO

Senator **Inouye**. Our next witness has been called the conscience of the Senate at times, and at times the Senator's Senator.

I am pleased to call upon my colleague from the State of Ohio, Senator Metzenbaum.

Senator **Metzenbaum**. Thank you very much, Mr. Chairman.

I thank you for your kind introduction as well as for your longtime personal friendship.

As I sat here, I was thinking to myself, it is wonderful to gain a role of seniority and leadership. It gives you the privilege to start at 9 o'clock in the morning and listen to a long line of speeches by U.S. Senators.

I speak to you this morning on two issues. The one issue has to do with very little money, but it is probably one of the most heartrending, touching issues that I think we deal with in the U.S. Senate, or the Congress.

That has to do with those abandoned children that are AIDS babies, or otherwise drug related, and they are abandoned in the hospitals of this country. All one has to do is to go to one of those hospitals and see that little baby there with never a warm human arm to hold it except as the nurse finds 5 minutes or 10 minutes a day.

Now, last year, I authored legislation to address one of the most harrowing crises of having to deal with drugs in this country, and that has to do with these infants which have been abandoned by their parents who are drug involved. Some of these children have AIDS, for which there is no cure. There is no future except one of certain death within a reasonable period of years.

They are treated as outcasts by society. They are being warehoused in hospitals which, despite the best efforts of the staff, cannot hope to provide the love, the warmth, and the nurturing that all babies crave.

My bill, the Abandoned Infants Assistance Act of 1988, authorized the fantastically large sum of $12 million in fiscal year 1990 for projects to demonstrate the best methods of placing these babies in community-based, residential and foster care, so that some humans could put their arms around them and sing to them and hold them as they are fighting for their very lives.

That bill was signed into law October 18 of last year. For many infants who have been exposed to crack cocaine or PCP, a hospital ward is home, because their drug-addicted mothers simply cannot cope, and so they leave them and they never come back.

In many cases, they are set up for medical discharge, but they simply have no place to go. In testimony before the House Education and Labor Subcommittee in 1987, the Surgeon General said that he favored supporting projects to demonstrate methods of encouraging families to serve as foster families for AIDS babies.

To be fair to the Surgeon General, he has tried to deliver. In 1988, HHS's Office of Human Development Service committed $2.8 million in discretionary grants to demonstrate methods of care and placement of HIV positive, ARC, and AIDS children.

But that is not enough. Some of the demonstrations that were funded are multiyear commitments for which there is no funding assurance in 1990 or 1991. I am concerned that changes in policy at HHS, budget cutbacks, or possible Gramm-Rudman sequestering could eliminate these demonstrations before they have a chance to prove their merit.

These little babies have no lobby. They do not even have many friends, except those nurses who see them daily. So it is we who must have some loving care and kindness for them.

Another problem is that the existing demonstration projects are limited to HIV positive, ARC, and AIDS children. They do not address the additional problem of how to provide care for drug-addicted babies who have been abandoned in hospitals.

Mr. Chairman, in this instance, I personally appeal to your committee to provide the $12 million in the 1990 Labor-HHS appropriations "Human Development Service" account. That modest appropriation is supported by the American Academy of Pediatrics, the Child Welfare League, and other organizations in the vanguard of the treatment of pediatric AIDS.

The fact is that GAO has estimated the expenditure will actually save the Government money in the long run, since the annual cost of warehousing—a terrible term, if I may say so—one of these infants in a hospital can run as high as $250,000 for one.

My appeal is not based solely on the financial cost of a tragedy that leaves babies to grow up in hospitals. It is based on a human cost of our failure to help that group of people in this country who are the most innocent, the most helpless victims of the drug crisis in this country, and I appeal to you for that $12 million.

On another subject, totally different and far removed, in the 100th Congress, the trade bill contained a provision authorizing $980 million in worker retraining and adjustment assistance.

The purpose of that amendment was to improve and extend the scope of services under title III of the Job Training Partnership Act.

The administration has decided to ask for only $400 million for this program. Now, every year, there are some 2 million workers—2 million workers—who lose their jobs due to plant closings, relocations, technology changes, and othr causes.

In this instance, we battled about the plant closing legislation, but part and parcel of that package was the $980 million for retraining and relocation.

The Reagan administration's own blue ribbon task force recommended funding at the $980 million level. The legislation of the trade bill assigned a number of substantial new responsibilities to States and local entities, and $400 million is simply an inadequate amount to carry out these duties.

With these new responsibilities, rapid response capability so that when a plant closes down, the State can send a strike force in immediately to try and help those employees before they disperse and go out into the community and cannot be found—this could help with the economy and help to keep the economy healthy.

That strike force, that SWAT squad, could move in and respond quickly to plant closings and layoffs. The $400 million figure could actually mean that we will serve less people this year than we did last year, unless the appropriation is increased.

Since the original $980 million figure assumed that trade adjustment and assistance activities would be folded in under title III, and they have not been, I do not seek the full $980 million appropriation. However, I do believe that an appropriation of $745 million is the absolute minimum level necessary to deliver on the commitment that we made last year to dislocated workers and to American business.

Mr. Chairman, members of this committee, I appreciate your patience in hearing me.

Senator INOUYE. Your concern for the helpless, the innocent, and the blameless children with AIDS, I believe, will be responded to by the committee.

As you know, the administration came forth with zero request, but I am certain that we can do much, much better than that, sir.

Senator METZENBAUM. I certainly hope so.

Senator INOUYE. On your matter of the $745 million, how many men and women would be served by that?

Senator METZENBAUM. Approximately 2 million people are dislocated. I cannot say they will all be served by that, but I can say that certainly a very substantial number of them will be, and to get them back into the work force is a way of keeping our own Treasury better off. Instead of paying them welfare benefits and unemployment benefits, we will be putting them on the payroll, and they will be bringing taxes into our own Government.

Senator INOUYE. Your contention is that the amount enacted in the last fiscal year is woefully inadequate?

Senator METZENBAUM. It certainly is. It cannot do the job. We placed more responsibilities on the States, and we are giving them less money to do it. It just does not make good sense to pass a good piece of legislation, and then not provide the funding for it. That is obviously wrong. I am not asking for the entire amount, but with $980 million originally mentioned in the bill, and the legislation supported by the administration—we are only asking for $745 million.

Senator **Inouye**. Senator Adams, any questions?

Senator **Adams**. Thank you, Mr. Chairman.

Thank you, Senator Metzenbaum, for your excellent statement, and also thank you for your commitment to those who have no one to speak for them. I am grateful for your statement.

Senator **Metzenbaum**. Thank you, Senator.

Senator **Inouye**. Thank you, sir.

Senator **Metzenbaum**. Thank you.

STATEMENT OF HON. BOB KERREY, U.S. SENATOR FROM NEBRASKA

Senator **Inouye**. Our next witness is a new member of the U.S. Senate, and one that all of us are very proud of. He is the real, bona fide hero of ours, the former Governor of Nebraska, and someone that we look forward and expect much from—at least I do.

Senator **Kerrey**. Thank you, Mr. Chairman.

Senator **Inouye**. I am pleased to welcome you to my committee, sir. Senator Kerrey.

Senator **Kerrey**. Thank you, Mr. Chairman, and members of the committee.

I appreciate this opportunity to testify. I am essentially adding additional testimony. I have got a complete statement that I would ask to be submitted into the record.

Senator **Inouye**. Without objection, so ordered.

Senator **Kerrey**. I am adding additional testimony to that of the senior Senator from Nebraska, Senator Exon, on a program that is extremely important in Nebraska. It ends up being one of those that after it has been around a long time, people forget the original purpose, and it becomes a ready target—and that is impact aid, a program with which I believe, Mr. Chairman, you are also very familiar.

Before I get into that, one advantage that I have, which is perhaps a disadvantage to you, is to listen to other Senators as they have testified.

Senator Metzenbaum's support for the additional money for job training—I should comment on that, since as a Governor of Nebraska I used that job training money. It is an extremely important program when workers are dislocated. It is a program where if you see it in practice, it is one of those few programs where people come and thank you for actually having had it in place.

It enables people to increase their skills and move up in the job ladder, move into positions of greater responsibility, as well as individuals who are dislocated by technology displacement and other sorts of things.

It is a terrific program, and whether or not you can find $745 million, I do not know. But I just would offer my personal experience with that program as testimony to its effectiveness.

As to the impact aid, the 81st Congress of four decades ago first put Public Law 81-374 in place. As I said, it is one of those programs that begins, after awhile, to be forgotten. It is forgotten why we did it in the first place.

It is a program that is there because of taxes that are lost as a consequence of Federal ownership, and for lost revenue to local entities of Government from federally connected parents.

This is not a giveaway of Federal tax dollars. It is not charity—it is, in fact, a Federal responsibility, much the same way that any owner of property would understand that they have a responsibility for paying taxes for the maintenance of schools, taxes for the maintenance of Government services.

It is the responsibility that property owners understand all too well when they look at the negative consequences of not making those tax payments.

From the standpoint of the Federal Government, on the other hand, very often the consequences are not terribly negative. It is possible for the Federal Government to make a reduction in impact aid without a great deal of negative and adverse consequence to the Federal Government. The negative and adverse consequence falls entirely upon local government.

Over the last 8 years, the impact aid program, like many other education programs, has been cut dramatically. In fiscal year 1988, funding for impact aid was 5 percent less than fiscal year 1980 funding, before adjusting for inflation. After inflation, the fiscal year 1988 impact aid budget represented a 42.7-percent cut from the fiscal year 1980 level.

The 3(b) program fared even worse than the overall funding program during the 1980's. In real dollars, funding for the 3(b) student has been reduced by over two-thirds.

While Congress, I believe wisely, resisted the past administration's efforts to eliminate the 3(b) program, districts with a large number of children whose parents either live or work on Federal property have experienced financial hardships as a result of these shortsighted cuts.

This has been especially difficult at the local levels such as Nebraska that experienced agricultural recessions that further depleted the local capacity to fund themselves, and for local areas like Nebraska that depend to a large extent upon property taxes for the funding of education.

It is estimated in Nebraska that there are 15 school districts that will be eligible for impact aid this year, and in four of those districts—Bellevue, Macy, Santee, and Winnebago—over 60 percent of the students fall under either the 3(a) or the 3(b) category. As such, every cut in impact aid can be devastating to these schools. Every increased dollar is sorely needed.

Mr. Chairman, as you know, these impact aid funds are not a luxury for these school districts. These funds pay for bread and butter operating costs, for textbooks, and for teacher salaries, and I urge the subcommittee today that federally impacted schools can absorb no more costs, no more cuts, and in fact that an increase in the financial support of these schools is essential.

There is a growing awareness in Congress and throughout the Nation that education is the key to opportunity, and to our international competitiveness. In fact, in this administration, there is increased attention paid to education and an increased focus upon the local entities of Government taking charge and living up to their responsibility.

Mr. Chairman, what I am simply urging is that the Federal Government live up to its responsibility as well under the impact aid program.

I believe that we should act upon what is a growing consensus in the Nation, with a renewed commitment to live up to the Federal responsibility. I appreciate very much, Mr. Chairman, your permitting me to submit my full testimony for the record.

Senator **Inouye**. Sir, I believe you have hit upon the proper word, responsibility, because many of us over the years have suggested—especially in the case of some of your citizens, the Indians—that we have a special trust responsibility which we have failed to carry out over the years.

I can assure you that whatever I can do, everything will be done to make certain that the responsibility of this Government is not only recognized but carried out in the State of Nebraska.

Senator **Kerrey**. Thank you, Mr. Chairman.

Senator **Inouye**. Your words have been very important to us.

Senator Adams.

Senator **Adams**. Thank you, Mr. Chairman.

Senator Kerrey, I very much appreciate your statement, particularly on impact aid.

My State is one that suffers greatly from the burden of being unable to tax Federal lands, both Indian lands and other types of federally owned property, and impact aid is essential to us.

We have one school district, for example, where 51 percent of the students are students that must be supported by impact aid. Later on, Mr. Chairman, as the committee deliberates this, I will have an amendment and perhaps we could work something out in the bill.

The special education programs in States like my own, where we have a special education program for the disabled which is in excess of the Federal program, is having the effect in the impact aid area of reducing the amount of impact aid available for the other students, particularly in the Indian reservations and in certain of our military reservations.

So I am very pleased that you have brought that subject, as well as others, before us today. It is a very difficult subject, and it is one that we have struggled with for many years. But there is no way that Western States and States with a great deal of Federal property can pay for their schools when they do not have a tax base unless there is impact aid programs.

It is in lieu of taxes, and we hope we will continue to treat it as such. I thank you for your statement—it was excellent—and I thank you, Mr. Chairman.

Senator **Kerrey**. Thank you.

Senator Adams, I would be remiss if I did not say that I am very much aware of the impact on special education. I would not want the general statements I have made here to be construed as suggesting that I am not concerned about increasing our attention, particularly on Indian reservations where the dropout rate is extremely high, and the educational effort becomes terribly important, if you believe, as I do, that we do have a responsibility to work toward breaking the cycle of poverty that has dominated life on the reservation for so long.

PREPARED STATEMENT

I think we have a special and renewed responsibility in the 1990's to do all that we can to break that cycle.

Senator **Inouye**. You have hit it right on the head, sir.

Senator **Kerrey**. Thank you.

[The statement follows:]

STATEMENT OF SENATOR J. ROBERT KERREY

Mr. Chairman, I would like to thank you and the Committee for allowing me this opportunity to testify on behalf of a program fundamental to educational excellence and opportunity in the Nation, and particularly in the state of Nebraska.

Almost four decades ago, the 81st Congress formally acknowledged a key responsibility to children and school districts across the nation. By enacting P.L. 81-374, the Impact Aid program, the federal government recognized its duty to reimburse school districts for the property tax foregone because of federal ownership, and for lost revenues from "federally-connected" parents.

This was no federal giveaway. It was not charity. This was federal responsibility.

Few localities rely on impact aid as heavily as Nebraska. With the Strategic Air Command, Offutt Air Force Base and a number of Native American reservations within our borders, Nebraska cannot afford for the federal government to renege on its fundamental duties. In addition, the state of Nebraska relies heavily on property taxes as the primary source of school funding. Any loss of revenue as a result of federal activities would be devastating without the compensation granted under the impact aid program.

An analogy is often made between individual property holders and the federal government when it owns land in a school district. The analogy is apt and useful, I think, in demonstrating that the federal government must own up to its responsibilities when it removes valuable property from a district's tax base.

Unfortunately, the comparison breaks down in its practical application; while a property owner faces severe penalties for refusing to pay property taxes owed, the federal government can cut impact aid funding at will. And it has.

Over the past eight years, the impact aid program, like so many other essential education programs, has been slashed. For example Fiscal Year 1988 funding for impact aid was 5 percent less than fiscal year 1980 funding before adjusting for inflation. After inflation, the FY88 impact aid budget represented a 42.7% cut from the FY80 level.

The 3(b) program fared even worse than the overall program during the 80s; in real dollars, funding for 3(b) students has been reduced by over two-thirds. While Congress wisely resisted the past Administration's attempts to eliminate the 3(b) program, districts with a large number of children whose parents either live or work on federal property have experienced financial hardship as a result of these shortsighted cuts.

It is estimated that 15 Nebraska school districts will be eligible for impact aid this year. In four of those districts -- Bellevue, Macy, Santee and Winnebago -- over 60 percent of the students fall under the 3(a) or 3(b) categories. As such, every cut in impact aid can be devastating to these schools. Every increased dollar is sorely needed.

Mr. Chairman, as you know, impact aid funds are not a luxury for these school districts. These funds pay for bread-and-butter operating costs, for textbooks, for teacher salaries. I urge upon the Subcommittee today, that federally-impacted schools can absorb no more cuts, and, in fact, that an increase in financial support for these schools is essential.

There is a growing awareness in Congress and throughout the nation that education is the key to opportunity and to our international competitiveness. Increasingly, it is understood that, even during a deficit crisis, cuts in education programs will merely rob us of future greatness.

Let us act on this growing consensus with a renewed commitment to education funding. Let us begin by fulfilling the duties of the federal government as a local property owner and employer. Let us again commit ourselves to adequate support for impact aid.

STATEMENT OF HON. PAUL SIMON, U.S. SENATOR FROM ILLINOIS

Senator INOUYE. Our next witness is one of the most distinguished members of our body, who nearly became President. I am pleased to call upon my colleague from Illinois, Senator Simon.

Senator SIMON. I thank you, Mr. Chairman. It is an honor to testify before you, and my colleague on two other committees, and our colleague from the State of Washington.

I would like to enter my full statement in the record, if I may.

I would like to talk to you just very briefly about the JTPA program, and then also on education programs, in general.

On the JTPA program, every analysis that I have seen suggests that it really pays off for this country. We are training people who desperately need that training.

But, we are reaching only about 5 percent of those who could be reached. We are in absolute dollars in fiscal year 1989 appropriating a little less than we did in fiscal year 1984.

That means in fact about a 22-percent drop in funding, when you consider inflation. We will probably pass a bill out of my Subcommittee on Employment and Productivity—Senator Adams is a member of that subcommittee, so I have to speak with some tentativeness here—that will authorize a greater appropriation, that will correct the deficiencies of the program, and also recognize that in the JTPA program we have not reached the really hard to employ population as much as we should.

It is very interesting that the Secretary of Labor has an advisory committee, and it has made suggestions for changes in the JTPA program. They very closely parallel what I have suggested in a bill, S. 543, that I have introduced in the Senate.

I would add, because I just heard the discussion that you had with Senator Kerrey on education, that I think we have to make a much greater priority of education, in general, and JTPA is one small part of that.

I heard you talking about the aid to the handicapped program, Public Law 94-142. I helped to create that law some years ago, when I was in the House of Representatives. In theory, the Federal Government should be providing the 40-percent funding level in assistance to schools for the handicapped—40 percent of the average per pupil cost of education.

We are about at the 8-percent level. It is a substantial distance from where we said we were going to be.

Just in general, if one were to look at the Federal budget, and ask what is the threat to the United States, one would say really the only threat must be Soviet military power.

I do not for a moment question that that continues to be a threat, but I think it probably is a diminishing threat, and we are now in a very different kind of threat. We are in competition now, particularly with Japan, but also with West Germany, with Sweden, and with a great many other countries.

I think we are going to have to put much greater stress on education than we have in the past. I am going to be offering an amendment today on the floor suggesting that we shift $3 billion in budget authority from the defense budget—about 1 percent—over to education.

I think we have to recognize education has to become a much greater priority in this Nation, and what we will be asking from my subcommittee for JTPA funding is a small part of where I think we ought to be going.

I would be happy to answer any questions you may have, Mr. Chairman.

Senator INOUYE. Your leadership in this area is much appreciated, because I still remember those terrible statistics that came from the Secretary of Education, about 6 years ago, when he reported rather casually that 52 percent of Hispanic adults are functional illiterates, 47 percent of adult blacks are functional illiterates, 17 percent of adult whites are functional illiterates, and 13 percent of high school graduates were in that category.

Today, as you are well aware, we depend upon volunteers to put on the uniform of this country. The Army recruiting program is finding great difficulty in recruiting those with the experience and background necessary to defend us. About 10 percent of those who sign up are functional illiterates in the U.S. Army.

Now, I would hope that the administration would look at those numbers and get a little concerned, the way we are, sir.

Senator SIMON. I could not agree more.

Ironically, just today the Secretary of Education is going to release a report about where we are. He was on "The Today Show" this morning, where he said that in the last 3 years we have made no progress at all in the field of education.

It is interesting that the President was going to appear with Secretary Cavazos today as the administration released the report on the status of education, but the President has decided not to appear with him. My guess is that he declined because it is such a pessimistic report in terms of how we are really meeting these needs.

I wish we had more leaders like you, my colleague from Hawaii. I am very proud to serve with you.

Senator INOUYE. You are very kind, sir.

It may be strange for one who serves now as chairman of the Defense Appropriations Subcommittee to be saying this, but the real strength of our country is not the missile, but the people, and if they are not strong, you can have all the missiles you want. It will be for nought.

PREPARED STATEMENT

Senator **Simon**. You are absolutely correct, and coming from you, it has added weight, and I thank you.

Senator **Inouye**. Thank you very much.

[The statement follows:]

STATEMENT OF SENATOR PAUL SIMON

MR. CHAIRMAN, AND MEMBERS OF THE SUBCOMMITTEE, IT IS A GREAT HONOR AND A PRIVILEGE FOR ME TO APPEAR TODAY BEFORE THIS DISTINGUISHED SUBCOMMITTEE. I AM HERE TO TESTIFY REGARDING THE FEDERAL SUPPORT NEEDED FOR IMPORTANT TRAINING, EMPLOYMENT, EDUCATION AND LITERACY PROGRAMS THAT MAKE A TREMENDOUS DIFFERENCE IN THE LIVES OF MILLIONS OF PEOPLE WHO ARE THE FUTURE OF THIS NATION. IN PARTICULAR, I WANT TO SPEAK ON BEHALF OF THE POOR, MINORITIES, OUR CHILDREN AND OUR YOUTH - CONSTITUENCIES WHO MAY NOT VOTE, LOBBY, OR SPEAK FOR THE PROGRAMS WHICH ARE AT LEAST AS CRITICAL, IF NOT MORE CRITICAL, TO OUR NATIONAL SECURITY AS THE PENTAGON.

AS CHAIRMAN OF THE SUBCOMMITTEE ON EMPLOYMENT AND PRODUCTIVITY, I HAVE BECOME INCREASINGLY CONCERNED ABOUT OUR NATION'S MOST DISADVANTAGED CITIZENS, AND OUR YOUTH IN PARTICULAR, WHO LACK THE BASIC SKILLS NEEDED TO FIND AND KEEP JOBS TO SUPPORT THEMSELVES AND THEIR FAMILIES. WE ALL KNOW THE STATISTICS, AND THEY ARE SHOCKING. SOME 23-25 MILLION AMERICANS ARE CONSIDERED FUNCTIONALLY ILLITERATE. MORE THAN 13 PERCENT OF WHITE, 17 PERCENT OF BLACK AND 29 PERCENT OF HISPANIC YOUTH AGES 18 TO 21 ARE HIGH SCHOOL DROP OUTS. THE AVERAGE AMERICAN HIGH SCHOOL GRADUATE SEEKING A JOB READS AT THE LEVEL OF AN AVERAGE EIGHT GRADER. ONE FOURTH OF THESE GRADUATES READ AT THE SIXTH GRADE LEVEL.

THESE STATISTICS CARRY WITH THEM FRIGHTENING IMPLICATIONS FOR OUR NATION'S ECONOMIC SECURITY AND PROSPERITY. AS WE MOVE INTO THE 21TH CENTURY, WE MUST ACKNOWLEDGE THAT THE WORKFORCE OF TOMMOROW WILL BE VERY DIFFERENT THAN THAT OF TODAY. OVER THE NEXT TEN YEARS, ONLY 15 PERCENT OF NEW ENTRANTS TO THE LABOR FORCE WILL BE WHITE MALES, COMPARED TO 47 PERCENT TODAY. MINORITIES AND WOMEN WILL BE THE MAJORITY OF NEW WORKERS AND THEY MUST BE PROPERLY EDUCATED AND TRAINED TO PARTICIPATE FULLY AND PRODUCTIVELY IN OUR EVER-CHANGING ECONOMY. TRAINING AND RETRAINING MUST BE PROVIDED TO DISLOCATED WORKERS WHO CRAVE EDUCATION, TRAINING AND TRANSITION ASSISTANCE INTO NEW JOBS. THESE JOBS WILL BE IN THE SERVICE INDUSTRIES AND WILL DEMAND DIFFERENT AND HIGHER SKILL LEVELS THAN THOSE OF TODAY. VERY FEW JOBS WILL BE AVAILABLE TO THOSE WHO ARE AMONG THE LEAST SKILLED. AND, INDEED, THE PERSON WHO CANNOT READ, COMPUTE, AND EFFECTIVELY COMMUNICATE WILL BE EFFECTIVELY DISENFRANCHISED FROM THE LABOR FORCE ALTOGETHER.

AS PART OF THE NATIONAL INVESTMENT IN OUR NATION'S ECONOMIC FUTURE, I URGE YOU TO APPROVE INCREASED APPROPRIATIONS IN FY 1990 FOR THE JOB TRAINING PARTNERSHIP ACT (JTPA). AS YOU KNOW, JTPA IS A FEDERAL, STATE AND LOCAL PARTNERSHIP PROGRAM TO TRAIN DISADVANTAGED ADULTS AND YOUTH AND DISPLACED WORKERS. IT IS ONE OF THE BEST KEPT SECRETS IN TOWN. JTPA, WHICH REPLACED THE OLD CETA PROGRAM, IS THE CENTRAL FEDERAL PROGRAM DESIGNED TO EQUIP ECONOMICALLY DISADVANTAGED YOUNG PEOPLE AND ADULTS - HIGH RISK YOUTH, HIGH SCHOOL DROP OUTS, PERSONS ON WELFARE, THE HARD CORE UNEMPLOYED - WITH THE BASIC EDUCATION AND WORKPLACE SKILLS NEEDED TO OBTAIN AND KEEP A JOB PAYING A DECENT SALARY.

WHILE IMPROVEMENTS ARE CERTAINLY NEEDED IN THE JTPA PROGRAM TO BETTER TARGET ITS RESOURCES AND SERVICES TO THE MOST NEEDY AND LEAST JOB READY INDIVIDUALS, THE JTPA PROGRAM HAS ENCOUNTERED NONE OF THE ABUSES FOUND IN THE OLD CETA PROGRAM AND, IN FACT, IS UNIQUE AMONG FEDERAL PROGRAMS IN ITS PUBLIC ACCOUNTABILITY. PERFORMANCE STANDARDS ARE AN INTEGRAL PART OF LOCAL JOB TRAINING PARTNERSHIPS THAT HELP TO ENSURE A HIGH RETURN ON THE FEDERAL INVESTMENT.

THE JTPA YOUTH EMPLOYMENT AMENDMENTS OF 1989, S. 543, THAT I HAVE INTRODUCED AND INTEND TO MARKUP DURING THIS SESSION WOULD FURTHER STRENGTHEN JTPA'S FOCUS ON LOW-INCOME PERSONS WHO LACK THE BASIC SKILLS NECESSARY TO ENTER AND PERFORM WELL IN THE LABOR MARKET. MY BILL WOULD ALSO PROVIDE STRONG INCENTIVES FOR LOCAL SERVICE PROVIDERS TO CONDUCT MORE INTENSIVE TRAINING, HELPING PARTICIPANTS SECURE MORE HIGHLY SKILLED JOBS WITH POTENTIAL FOR ADVANCEMENT, RATHER THAN DEAD-END, LOW-PAYING JOBS.

MR. CHAIRMAN, AS PART OF THE EFFORT TO REFOCUS THE JTPA SYSTEM ON THE NEEDIEST INDIVIDUALS, AND YOUTH IN PARTICULAR, WHO NEED MORE INTENSIVE (AND MORE

COSTLY) INTERVENTION, I URGE THIS COMMITTEE TO APPROVE AN INCREASE OF $300 MILLION OVER FY 1989 APPROPRIATIONS FOR JTPA EVENLY DIVIDED AMONG TITLE II-A, TRAINING FOR DISADVANTAGED ADULTS AND YOUTH, TITLE II-B, SUMMER YOUTH EMPLOYMENT, AND TITLE III- DISLOCATED WORKERS.

THE JTPA PROGRAM HAS **NOT** BENEFITTED FROM MEANINGFUL FUNDING INCREMENTS OVER THE YEARS. AND, AS A RESULT, THE FEDERAL INVESTMENT IN IT HAS ACTUALLY DECLINED. IN FY 1989, WE ALLOCATED $2.8 BILLION FOR TITLE II A & B AND TITLE III OF JTPA - AN AMOUNT LESS THAN THE $2.9 BILLION ALLOCATED FOR THESE PROGRAMS IN JTPA'S FIRST YEAR OF OPERATION! **FEWER** PERSONS ARE PARTICIPATING IN THESE PROGRAMS THAN DID IN ITS FIRST YEAR. YET, THE NEED IS AS GREAT OR EVEN GREATER! IF WE ADJUSTED FOR INFLATION, MORE THAN $700 MILLION WOULD BE REQUIRED FOR TITLES II AND III IN FY 1990 TO MAINTAIN THE SAME LEVEL OF SERVICE PROVIDED IN THE FIRST FULL YEAR OF JTPA. I AM ASKING THAT YOU APPROVE AN INCREASE LESS THAN HALF OF THAT AMOUNT FOR A PROGRAM THAT IS SEVERELY HINDERED BY LACK OF RESOURCES.

CURRENTLY, JTPA SERVES ONLY ABOUT 5 PERCENT OF THOSE WHO ARE ELIGIBLE FOR SERVICES. PUT ANOTHER WAY, **95 PERCENT OF THOSE WHO ARE ELIGIBLE AND WHO NEED JTPA SERVICES DO NOT RECEIVE THEM**. THERE IS A CRITICAL NEED TO FOCUS, IN PARTICULAR, ON OUR NONCOLLEGE BOUND YOUTH WHO HAVE BECOME "THE FORGOTTEN HALF" I SUPPORT THE AVERAGE $5000 PUBLIC AND PRIVATE SUBSIDY THAT EACH STUDENT ENROLLED IN HIGHER EDUCATION CAN EXPECT TO RECEIVE EACH YEAR IN SCHOLARSHIPS AND GRANTS. BUT, WHAT ABOUT THE NONCOLLEGE BOUND YOUTH WHO, IF THEY ARE LUCKY ENOUGH TO PARTICIPATE IN JTPA AT ALL, CAN EXPECT A FEDERAL INVESTMENT OF ONLY ABOUT $1800 FOR FOUR MONTHS OF TRAINING?

JTPA IS A PROGRAM THAT IS UNIQUELY POSITIONED TO DEAL WITH THE WIDENING GAP BETWEEN THE INCREASING SUPPLY OF UNSKILLED (AND OFTEN UNEDUCATED) LABOR AND THE DECREASING DEMAND FOR UNSKILLED LABOR. INCREASED EDUCATION, BASIC SKILLS AND JOB TRAINING - AND REAL EQUAL EMPLOYMENT OPPORTUNITY - CAN IDEALLY BE PROVIDED THROUGH THE JTPA SYSTEM; A SYSTEM IN WHICH 92 PERCENT OF ITS PARTICIPANTS ARE ECONOMICALLY DISADVANTAGED, 53 PERCENT ARE FEMALE, 45 PERCENT ARE MINORITIES AND 40 PERCENT ARE PUBLIC ASSISTANCE RECIPIENTS.

JTPA MERITS YOUR ATTENTION AS A WISE AND EFFECTIVE USE OF OUR NATION'S SCARCE RESOURCES. AS ONE OF THE MEMBERS OF THE JTPA ADVISORY COMMITTEE TO LABOR SECRETARY DOLE COMMENTED: "THE JOB TRAINING PARTNERSHIP ACT IS SOMETIMES CALLED THE SECOND CHANCE SYSTEM, SOMETIMES CALLED THE LAST CHANCE SYSTEM. FOR SOME AMERICANS IT IS THE ONLY CHANCE THEY HAVE TO BECOME THE PRODUCTIVE CITIZENS THAT THEY WISH TO BE AND THAT OUR COMMUNITIES, OUR ECONOMY AND OUR COUNTRY NEEDS THEM TO BE."

I WOULD ALSO URGE YOU TO CONSIDER SUBSTANTIAL SPENDING INCREASES IN EDUCATION PROGRAMS. IN EDUCATION, LIKE ALMOST EVERYTHING ELSE, WE TEND TO GET WHAT WE ARE WILLING TO PAY FOR. AND RIGHT NOW, WE ARE NOT PAYING ENOUGH TO ENSURE ACCESS TO EARLY CHILDHOOD EDUCATION, TO FULLY FUND THE CHAPTER 1 PROGRAM, TO STEM THE MASSIVE HIGH SCHOOL DROP OUT RATES, TO GUARANTEE A POSTSECONDARY EDUCATION FOR EVERY STUDENT, AND TO ELIMINATE ADULT ILLITERACY BY THE YEAR 2000. WE NEED A NATIONAL CAMPAIGN TO WIPE OUT ADULT ILLITERACY BY EXPANDING BOTH PUBLIC AND PRIVATE EFFORTS TO REACH OUT AND TEACH PEOPLE TO READ AND WRITE - GIVING THEM DIGNITY AND HOPE. I PLAN TO INTRODUCE SOON A MAJOR INITIATIVE TO DO JUST THAT.

MR. CHAIRMAN, I BELIEVE THAT THERE ARE NO ISSUES MORE IMPORTANT THAN EDUCATING AND TRAINING PEOPLE SO THAT THEY CAN REACH THEIR FULL POTENTIAL. EVERY AMERICAN SHOULD BE ABLE TO READ AND WRITE, TO HAVE THE OPPORTUNITY TO OBTAIN A GOOD EDUCATION, AND TO HOLD A DECENT JOB. AS A MEMBER OF THE SENATE BUDGET COMMITTEE, I HAVE WORKED HARD TO ENSURE THAT THE FY 1990 BUDGET RESOLUTION INCLUDES SUFFICIENT RESOURCES IN FUNCTION 500 SO THAT THIS SUBCOMMITTEE WILL HAVE THE FLEXIBILITY TO INVEST IN EDUCATION AND TRAINING. MORE THAN $3 BILLION IS REQUIRED JUST TO MAINTAIN THE LEVEL OF INVESTMENT THAT WE MADE IN EDUCATION PROGRAMS THE 1980-81 SCHOOL YEAR. AND, WHILE I RECOGNIZE THAT YOUR JOB THIS YEAR WILL BE EXTREMELY DIFFICULT DUE TO THE FEDERAL DEFICIT, I STRONGLY ENCOURAGE YOU TO MAKE A COMMITMENT TO A REAL AND A MEANINGFUL INCREASE IN FEDERAL APPROPRIATIONS TO ADDRESS THE NATIONAL EDUCATION AND TRAINING DEFICIT.

NONDEPARTMENTAL WITNESSES

STATEMENT OF DR. CHRISTIAN GULBRANDSEN, ACTING DEAN, JOHN A. BURNS SCHOOL OF MEDICINE, UNIVERSITY OF HAWAII

Senator INOUYE. Now we will hear from citizens who are not members of the U.S. Senate.

We have a group of citizens from the State of Hawaii, and I would like to first call upon the acting dean of the John A. Burns School of Medicine of the University of Hawaii, Dr. Christian Gulbrandsen.

Senator INOUYE. Dean Gulbrandsen, I am very pleased to have you with us, sir.

Dr. GULBRANDSEN. Thank you very much, Senator Inouye.

I appreciate being able to testify before this subcommittee today. I am Christian Gulbrandsen, the acting dean of the John A. Burns School of Medicine, speaking on behalf of the Pacific Islands Health Officers Association, which is comprised of the health leadership from Micronesia, the Commonwealth of the Northern Mariana Islands, Guam, and American Samoa.

This testimony concerns the continuation and development of a strategy to address the health manpower needs of the Pacific Basin.

For the past 23 years, the University of Hawaii School of Medicine has been involved in assisting the Pacific Basin countries to address issues related to health delivery through the development of health manpower, first, through the training of physician assistants and Medex, second, the development of rehabilitation technicians, and, third, and most recently, the initiation of a Pacific Basin Medical Officers Training Program.

Today, the medical officers training program is in place with a total of 61 students from Micronesia and American Samoa. The first 17 students will graduate as medical officers in 2½ years.

These graduates will function as primary care physicians. As the next generation of indigenous health leaders, they will develop and implement health care systems that are appropriate and responsive to the real needs of the region.

The development of the training program is a part of an overall strategy of the University of Hawaii to address the health manpower shortage in Micronesia. It is going well, and enjoys the support of the countries in the Pacific.

Now, we are prepared to address the larger health manpower issues. It is proposed that top priority be given to the continuation of Pacific Basin Medical Officers Training Program on Pohnpei.

Additional manpower development projects which could be included are the establishment of nurse training programs and other health professional training initiatives, which include scholarships. These training efforts should be targeted toward ensuring that residents of the Pacific Basin attend and graduate from recognized health professional programs in medicine, dentistry, nursing, optometry, pharmacy, podiatry, public health, psychology, and allied health.

Provision should be made for continuing education which would support the upgrading of the health professional within the Pacific Basin as well as the residency training in primary care and preventive medicine for the National Health Service Corps officers assigned to the region.

The upgrading of currently employed Pacific Island health personnel would involve management and social services training. In addition, continuing technical training could be initiated for new health workers, which include environmental sanitation aides, social work assistants, community and hospital nurse assistants, and allied health technicians.

Finally, appropriate health promotion and disease prevention efforts in public health should be established with the citizens of the Pacific Basin.

The State of Hawaii, more specifically the University of Hawaii, is committed to share the responsibility of providing the leadership in the development of health manpower in the Pacific Basin. But Hawaii is unable to undertake the financial requirements which are needed to pursue the initiatives.

It is also obvious that if Hawaii does not pursue this commitment with the help of the Federal Government, health manpower development programs in the Pacific may not develop.

The support of this subcommittee has been vital and sincerely appreciated by those of us from the University of Hawaii, and by the Micronesian and Samoan leaderships. Thank you for the opportunity to testify this morning.

Senator INOUYE. I thank you very much, Doctor.

The records should indicate that what you have described is really an obligation and responsibility of the Federal Government of the United States.

When we undertook the responsibility of serving as trustees of Micronesia, we promised the world, through the United Nations, that we would do these things. Now we find that because of the shortcomings of our Federal Government, the State of Hawaii has been shouldering much of that responsibility.

Once again, the administration has requested zero dollars, and I feel confident that we will do something about this, also.

During a recent trip to Alaska, I met with many representatives in the Arctic Circle Indian villages. As you may know, these villages are rather isolated—there are no highways to connect them. The only way you can get there is on foot, or by dogsled during the winter, or by aircraft.

There are no physicians, there are no medical technicians. Each village has one, possibly two, community health aides who have received about 5 weeks of training.

I suggested that they should look seriously at the program that your school has started on Medex, and physicians assistants. It might be something worthy of your consideration, so if I may, I will have them call upon you, sir.

PREPARED STATEMENT

Dr. **Gulbrandsen**. Thank you. I would appreciate that.

Senator **Inouye**. I thank you very much, sir.

Dr. **Gulbrandsen**. A pleasure.

[The statement follows:]

STATEMENT OF DR. CHRISTIAN GULBRANDSEN

I am Christian Gulbrandsen, M.D., Acting Dean of the John A. Burns School of Medicine, speaking in behalf of the Pacific Islands Health Officers Association (PIHOA) which is comprised of the health leadership from Micronesia, the Commonwealth of the Northern Mariana Islands, Guam, and American Samoa. This testimony concerns the continuation and development of a strategy to address the health manpower needs of the Pacific Basin.

For the past twenty-three years, the University of Hawaii School of Medicine has been involved in assisting the Pacific Basin countries to address issues related to health delivery through the development of health manpower: first, through the training of physician assistants (Medex); second, the development of rehabilitation technicians; and, third, and most recently, the initiation of a 9 year Pacific Basin Medical Officers Training Program (PBMOTP), a concept conceived by the former Dean of the School of Medicine, Dr. Terence Rogers and made possible through the good offices of this Subcommittee.

Today, the Medical Officers Training Program is in place with a total of 61 students from Micronesia and American Samoa. The first 17 students will graduate as medical officers in two and one-half years. These graduates will function as primary care physicians. As the next generation of indigenous health leaders, they will develop and implement health care systems that are appropriate and responsive to the real needs of the region.

Because of the unusual characteristics of the students, there are special features of the Medical Officers Training Program which call upon innovative and practical approaches. For example, the first year students are exposed to an intensive "survival course" in English as a Second Language (ESL) since all students come from a multiplicity of languages. This course has a significant impact on study skills and the ease with which the students progress through the Program. In addition, all students and faculty receive a "crash course" in the Pohnpeian language delivered by a former Peace Corps language facilitator. This has obviated the need for an interpreter in the clinics and hospital where local patients are treated by the students and faculty. The curriculum is a community-oriented problem and competency-based approach designed for students with disadvantaged educational backgrounds. The curriculum is practical and appropriate to regional resources. Appropriate basic sciences are integrated from the outset into the clinical and public health training. Emphasis is given to those preventive and curative skills which are critical in the Pacific Basin.

In March of this year, the Western Pacific Regional Office of the World Health Organization declared the Pacific Basin Medical Officers Training Program a "significant educational institution" in the Pacific.

The development of the training program is a part of an overall strategy of the University of Hawaii to address the health manpower shortage in Micronesia. It is going well and enjoys the support of the countries in the Pacific. Now, we are prepared to address the larger health manpower issues.

It is proposed that top priority be given to the continuation of the Pacific Basin Medical Officers Training Program on Pohnpei. Additional manpower development projects which could be included are the establishment of nurse practitioner/nurse clinical specialist training programs and other health professional training initiatives which include scholarships. These training efforts should be targeted towards ensuring that residents of the Pacific Basin attend and graduate from recognized health professional programs in medicine, dentistry, nursing, optometry, pharmacy, podiatry, public health, psychology, and allied health. Parallel with these initiatives should be provisions for continuing education which would support the upgrading of the health professional within the Pacific Basin as well as the residency training in primary care and preventive medicine for the National Health Service Corps Officers assigned to the region. The upgrading of currently employed Pacific Island health personnel would involve management and social services training. In addition, continuing technical training could be initiated for new health workers which include environmental sanitation aides, social work assistants, community and hospital nurse assistants, and allied health technicians. Finally, a most important and significant area for inclusion in the overall strategy for health is the establishment and support of appropriate health promotion and disease prevention efforts in public health with the citizens of the Pacific Basin.

To mobilize the above activities, the young men and women of the Pacific Basin must be counseled and inspired to enter professions in health. It is proposed that a "Unified Health Training Program" such as that envisioned for Hawaii be implemented. This program is designed to recruit and to select trainees for health care careers. In such a program, students with a high school diploma desiring training in the health care fields will be enrolled in a program involving paid hospital work such as orderly and aide, a ward clerk, a lab assistant or an x-ray technician's assistant. At the same time the students are working, they will be trained in clinical sciences and will be educated in the humanities. The clinical training will teach them the basic sciences and clinical skills necessary to perform the next more sophisticated task required by the hospital. This training will be problem-based and evaluated using competency-based tools, and the students will proceed at their own pace. They may branch off into more intensive training in any of the health care fields should they desire and be capable, and they may challenge certifying examinations in the various health care fields after satisfying the competency-based evaluation. Education in the humanities will emphasize reading, writing, speaking, history, economics, and their role in society.

Such a program will recruit a heretofore untapped group of people into careers in health care. High school students from all levels of socioeconomic strata will apply for enrollment for a variety of reasons ranging from needing a job to interest in the health care fields as a career. Once in the program or while working in the hospital in a job side-by-side with a student in the program, workers will become aware of opportunities, talents, and interests which they may never have otherwise known. Students and workers currently involved in certain areas of health care will become aware of opportunities and follow their interests and abilities into further training. This program will select and self select people to various fields within the health care area according to their abilities, desires, and motivations. It will permit identification of people who care about caring for the sick. It will pay students as they learn, thereby attracting students from low economic strata and keeping them from getting into financial debt. It will allow students who must stop training for personal reasons to continue to work, make a living without being lost to the health care industry, and later resume training. This program will permit the various health care workers to know the tasks and roles of health care workers in different fields, thereby increasing mutual respect, decreasing fragmentation of health care delivery, and improving service to the sick. Finally, the program will help alleviate the health manpower shortage by increasing the number of health care trainees and trainers delivering care in the system.

The State of Hawaii, more specifically, the University of Hawaii is committed to share the responsibility of providing the leadership in the development of health manpower in the Pacific Basin. But, Hawaii is unable to undertake the financial requirements which are needed to pursue the initiatives. It is also obvious that if Hawaii does not pursue this commitment with the help of the Federal government, health manpower development programs in the Pacific may not develop.—

The support of this Subcommitee has been vital and sincerely appreciated by those of us from the University of Hawaii and also by the Micronesian and Samoan leaderships.

STATEMENT OF KILALI ALAILIMA, EXECUTIVE DIRECTOR, SAMOAN SERVICE PROVIDERS ASSOCIATION

Senator INOUYE. Our next witness is the executive director of the Samoan Service Providers Association. Most people are not aware that the Samoan population in Hawaii and on the west coast of the United States would outnumber the population in Samoa itself.

Like many unfortunates in our community, at this moment they are on the lowest rung of our social, economic, and political ladder. Ms. Alailima, youthful though she may be, is one of the pioneers in the effort to boost Samoans in our communities.

I am pleased to call upon you, Ms. Alailima.

Ms. ALAILIMA. Thank you very much, Senator.

Senator Inouye and members of the Senate Subcommittee on Labor, Health, and Related Agencies Appropriations, thank you for this opportunity to testify today.

I am Kilali Alailima, executive director of the Samoan Service Providers Association, or SPA, a nonprofit Samoan community-based organization that has advocated for the needs of Samoans in Hawaii for many years, and manages the Samoan JTPA training and employment program for the State of Hawaii.

Last year, I appeared before this same subcommittee to testify in support of the establishment of a Samoan employment and training program. I am here today to thank you, and to request funding for its continuation.

For Hawaii, this program has been a long time coming. With only 4 months under our belt—which is when we started—we have served already a total of 137 participants, mostly in training, placed 14 in unsubsidized employment, trained four Samoan bilingual job counselors, sponsored a career day, established job clubs, and a summer youth employment and training program.

Our accomplishments to date reflect our serious commitment to our mission of economic self-sufficiency, independence from Government assistance, and successful social adaptation of Samoans residing in the United States. It is inspired by the fact that the delivery of services is done not by a governmental entity, but by a grassroots organization, working in collaboration with Government and backed by hundreds of Samoan community people and supporters.

This in-kind contribution cannot be underestimated. The efforts of these volunteers have helped to support and extend our efforts into the Samoan community. As board members, they are also involved in program planning, policy development, and strategizing.

Most of our participants live in low-income, high-crime areas, and the environment has added additional barriers, primarily because outreach and recruitment efforts by other employment agencies to these depressed areas have been minimal.

Furthermore, the family oriented nature of our Samoan culture is such that individuals tend to seek assistance from within the family or extended family, rather than from outside entities. The Samoan community based organization with trained bilingual counselors has an important impact in the community, especially with those individuals who would not otherwise seek assistance from governmental entities.

Allow me just an example of where this organization has served as a bridgemaker with the wider community. An Asian employer of 40 Samoan employees sought our assistance in improving employee performance. A series of meetings with the employer and employees helped to clarify many of the misunderstandings between the employer and the Samoan employees, developed appreciation cross-culturally, and produced a draft for the company's first employee bilingual handbook.

This is just one of the many examples where we served as bridgemakers with Samoans and the wider community.

The 1980 census confirmed what many of us in the community already knew—that Samoans as a whole are not integrated into the mainstream America. The statistics are very discouraging for all of us.

In Hawaii, for example, well over one-third of our population is living at or below the poverty line. While they compose only 2 percent of the State population, they compose 7 percent of the adult incarcerated population, 12 percent of the incarcerated youth population, and 26 percent—and this is the most recent statistic—of the youth gang population.

Youth gang activities are on the rise in California and in Hawaii, and this development is of great concern to our community, because many of these gangs involve Samoan youth. The problems this community faces will require long-term intervention.

The solutions will not be as simple as just placing people directly into jobs. Many Samoans will need training in literacy and basic skills. Exoffenders are not only going to be needing training in job skills, but on how to avoid alcohol abuse, manage stress in the job and in the home.

We are developing workshops in cross-cultural adaptation and adjustment, as well as in financial management. This is in addition to the basic JTPA programs which we already provide.

We are seeking funding to expand our services for fiscal year 1990. We are also requesting that California and Washington be included. These communities also are facing very difficult times with the Samoan community.

We believe that demand for our services is sufficient to serve nearly twice as many people as we are currently serving.

The Hawaii State Department of Labor and Industrial Relations will continue to serve as fiscal agent and provide oversight to our program. This joint effort combines the strength of both organizations in a way that best ensures the effectiveness of the program.

In closing, we ask that you please support funding for Samoans. We are seeking a total of $2.5 million for all three States—California, Hawaii and Washington. I understand the other two communities are already submitting testimonies to this regard.

We believe an investment now will prevent problems that will be more costly to us in the future.

I would like to say at this time f'afsait tililaba—thank you very much.

Thank you, Senator Inouye, for your continued and wonderful effort to help our Samoans throughout the United States.

Thank you.

Senator INOUYE. I thank you very much, Ms. Alailima. If we were not successful in providing funds, would it mean that you would have to close your operations?

Ms. ALAILIMA. Well, I will tell you something.

It will not close our operations. We worked for the last 4 years with practically nothing, and we scrounged and we begged and we pleaded. If you close up our operations, we will not stop, but we will certainly reduce the effort that we have now.

Because you gave us this funding last year, we have been able to do so, so, so much more than we were able to do before. But our commitment—and this is not just myself, but the Samoans and the Samoan supporters that have backed us in this community—it will not stop us, but it will certainly hinder us.

Senator INOUYE. You can be assured of our continued support.

Ms. ALAILIMA. Thank you very much.

[The statement follows:]

STATEMENT OF KILALI ALAILIMA

INTRODUCTION

Senator Inouye and Members of the Senate Sub-Committee on Labor, Health and Related Agencies Appropriations. Thank you for this opportunity to testify today.

I am Kilali Alailima, Executive Director of the Samoan Service Providers Association (SSPA), a non-profit Samoan community based organization that has advocated for the needs of Hawaii's Samoans for many years and manages the Samoan JTPA Training and Employment Program for the State of Hawaii.

STATUS of the SAMOAN JOB TRAINING PROGRAM

Last year, I appeared before this same sub-committee to testify in support of the establishment of a Samoan Employment and Training program. I am here today to thank you for your support and to request funding for its continuation. For our respective communities in Hawaii and California, such a program has been a long time coming. With the JTPA funds that you provided us, we have been able to establish one program in Hawaii managed by SSPA and a second program in California managed by the National Office of Samoan Affairs (NOSA), to serve Samoan communities in San Francisco, Los Angeles and San Diego. With only four months under our belt, we have already served over 240 participants, placed 50 in unsubsidized employment, trained 10 Samoan bi-lingual job counselors, sponsored a career day, established job clubs and a Summer Youth Employment and Training Program.

Our accomplishments, to date, reflect our serious commitment to our mission of economic self sufficiency, independence from government assistance and successful social adaptation of Samoans residing in the United States. It is inspired by the fact that the delivery of services is done not by a governmental entity, but by grass roots organizations working in collaboration with government and backed by hundreds of Samoan community people and supporters. The in-kind contribution provided by these concerned citizens towards our program cannot be underestimated. Their activities compliment, support and extend our efforts into the Samoan community. As board members, they are also involved in program planning, policy development, and strategizing.

The Samoan community is an isolated community. As such, the majority of our clients not only come to us needing work or occupational skills but many need orientation in job seeking skills, utilizing systems of transportation and communication, as well as, acceptable practices of social interaction when communicating with non-Samoans.

Most of our participants live in low-income and high crime areas. The environment, has added additional barriers, primarily because outreach and recruitment efforts by other employment and training programs into these depressed areas have been minimal. Furthermore, the family-oriented nature of our Samoan culture is such that individuals are more likely to seek assistance within the family or extended family rather than from an outside agency.

A Samoan community based organization with trained bi-lingual counselors has an important impact in the community and especially with those individuals who would not otherwise seek assistance from employment agencies and other institutions. Their efforts not only have an influence on the client but also on the family. The following are examples of what our organization has encountered since we opened our doors in January.

I received a call from an irate and frustrated father last week regarding papers his son had asked him to sign. He could not read nor did he speak English, and was not going to sign anything he did not understand. A few minutes with our youth counselor cleared up the problem and soon he was happily signing his son into our program. Furthermore, our counselor convinced him to enroll into one of our literacy programs.

An Asian employer of forty Samoan employees sought SSPA's assistance in improving employee performance. A series of meetings with the employer and employees helped to clarify many misunderstandings, develop appreciation and awareness cross-culturally, and produced a draft for the company's first employee bi-lingual handbook.

A successful SSPA sponsored Career Day for Samoan youth featured a newly enrolled university student as guest speaker. For her college was only wishful thinking until she attended one of SSPA's outreach workshops for youths residing in public housing. There she learned of a special college program for the economically disadvantaged.

We have made a good beginning towards addressing the economic and training needs of our community and we have invested much in the development of a program that will be very important to Samoans in the years to come.

DESCRIPTION of the PROBLEM

The 1980 census confirmed what many in our community already knew. Samoans, as a whole, are not integrated into the ranks of the middle class. The statistics are discouraging. In Hawaii, for example, well over a third of the population was living at or below the poverty line. Roughly one family in three is receiving public assistance income, compared with one family in ten for all Hawaii. Half of all Hawaii Samoan families were making less than $10,652 per year. Samoan households on the average contained twice as many people (5.0 persons) than all Hawaii households (2.7 persons). They were also more likely to contain children under 18 years of age. Furthermore, about one family in four was without a male head of the family. Samoans are well over represented in the prisons. While they only compose 2% of the state population, they compose 12% of the incarcerated youth population and 7% of the incarcerated adult population.

There are an estimated 90,000 Samoans living in the state of California. Over half of all American Samoans in California are affected by chronic unemployment and under-development, and a growing rate of substance abuse, domestic violence and gang affiliation. San Francisco Unified School District officials reported that Samoans had the highest drop-out rate in its district. The Los Angeles area has the highest per capita participation in gang affiliation from the Samoan youth community.

Agencies that manage programs targeting the economically disadvantaged believe that the 1990 census will also show that a significant percentage of the Samoan population are still living below the poverty level. Youth gang activities are also on the rise both in Hawaii and in California. This development is of great concern for our community, because many of these gangs involve Samoan youth.

THE PROPOSED PLAN

Samoan Service Providers Association and the National Office of Samoan Affairs, will be funded through 1990 at the present level of $454,000 per agency. We are seeking funding to continue our services through 1991 and request $750,000 for each agency or a total of 1.5 million dollars for the Samoan JTPA program. We believe the demand for our services is sufficient to serve nearly twice as many people as we are currently serving.Additional manpower will be required not only to serve more but to enable us to do long term follow-up and monitoring. Our targeted groups will still be Samoan youth, single parents dependent on welfare, the elderly and the incarcerated Samoans.

The problems this community faces are going to require long term intervention; the solutions will not be as simple as placing people directly into jobs. Many Samoans will need training in literacy and basic skills. Ex-offenders are not only going to need training in job skills but how to avoid alcohol abuse and manage stress on the job and in the home. We are developing workshops in cultural adaptation and adjustment as well as financial management. This is in addition to the basic JTPA programs we provide, which includes classroom Occupational Training, classroom Remediation and Pre-Employment Training, On-the-Job Training and Summer Youth Employment and Training Programs.

We are also becoming well networked with other training and employment resource agencies and human service providers. They include employment service agencies, community colleges, apprenticeship programs, welfare assistance agencies and private employers. We use our Samoan radio and television and other Samoan networks to educate and outreach.

PROGRAM MANAGEMENT

The Hawaii State Department of Labor, in collaboration with the Samoan Service Providers Association and the Nation Office of Samoan Affairs will continue to be the fiscal agent and provide oversight and monitor the program. SSPA will be developing and managing program operations. This joint effort combines the strength of both organizations in a way that best insures the effectivness of the program.

In closing, we ask that you please support funding for the Samoans. We are seeking a total of 1.5 million for our program for the next fiscal year because we believe that our investment now will prevent problems that will be more costly for us in the future. Fa'afetai tele lava. Thank you.

STATEMENT OF HON. DANIEL K. AKAKA, U.S. REPRESENTATIVE FROM HAWAII

Senator INOUYE. The next witness is the distinguished senior Congressman from the State of Hawaii.

I am pleased to call upon my colleague, Representative Daniel K. Akaka.

Mr. AKAKA. Thank you very much, Senator Inouye.

It is really a pleasure for me to come before you and the Senate committee to talk about our native Hawaiians.

At the outset, I want to tell you how much I appreciate your work, and the people of Hawaii also appreciate what you have been doing for the people of Hawaii in the Congress of the United States.

I want to say that, in case some people are not aware of it, you have been the leading force here in the Congress to formulate and fashion programs that are helping the needs of the Hawaiians. People of Hawaii should know that.

In response to some of the many concerns you have brought to our attention, Senator, and Mr. Chairman, the delegation here in Congress has developed an aggressive agenda to establish programs to address the needs of the native Hawaiian community.

For example, last year, the Native Hawaiian Health Care Act was signed into law. This legislation is designed to improve the health status of native Hawaiians by making primary care services and health promotion and disease prevention services available to native Hawaiians.

A litany of statistics, surveys, and studies provide evidence of the grim reality that native Hawaiians have the lowest life expectancy of any population in the State of Hawaii. Native Hawaiians have the highest percentage of different forms of cancer, and the lowest cancer survival rate. Native Hawaiian infants have the highest incidence of infant mortality, congenital abnormality, and low birth rate, compared to infants of other populations in the State of Hawaii.

Also, native Hawaiians are at far greater risk of acquiring diabetes, heart disease, and hypertension at younger ages than are other populations in the State of Hawaii.

There is also clear evidence of psychological pressure within the native Hawaiian population. This is best represented by the fact that young adult and elderly men have higher rates of suicide than any other population in the State of Hawaii.

With the funding authorized by the Native Hawaiian Health Care Act, outreach, education and prevention programs can be established to address and hopefully solve some of the health problems that hinder the well-being of the native Hawaiian population.

Here again, Senator, you have been at the front, leading this act.

Another program which we anticipate will raise the hopes and expectations of native Hawaiians is the Native Hawaiian Education Act. This program is designed to reduce educational obstacles that many native Hawaiians encounter during their elementary and secondary school years.

The Native Hawaiian Education Act addresses the special needs of native Hawaiian students, and authorizes five supplemental educational programs for their benefit: One, model elementary curriculum development; two, family-based education centers; three, higher education fellowship assistance; four, gifted and talented development; and five, special education assistance.

Native Hawaiian children typically experience problems with motivation and self-esteem, and often fail to develop a drive to excel intellectually. The situation becomes increasingly worse as the students move up in grades, and again, Senator, you have been at the head and leading this act.

There are many more initiatives that have been advanced by this delegation to assist the native Hawaiian community. By this hearing today, we hope to gain a greater understanding of how these programs are working, and what more can be done to address the needs of native Hawaiians.

Senator, I did testify yesterday before the subcommittee on appropriations in the House, asking for funding for both our health and education programs before Chairman Natcher. This morning, I am sorry that I was late, because we had a caucus meeting on the budget with the budget committee.

But I am happy to be here to testify before you, and again, I thank you, Senator Inouye, for your initiative in organizing these hearings. I look forward to working with you on the concerns you raise today.

Thank you very much.

Senator INOUYE. We have here before us one of the great native Hawaiians. His ancestry is one that traces back to the great kings of our State. He is an educator and school principal at one time.

Sir, it is a great honor to have you testifying before us, and I can assure you that everything earthly possible will be done to help your brothers and sisters, our native Hawaiians.

Mr. AKAKA. Thank you.

I certainly appreciate what you have said.

Senator INOUYE. Thank you, sir.

STATEMENT OF HON. ENI FALEOMAVAEGA, DELEGATE FROM AMERICAN SAMOA

Senator INOUYE. Our next witness gives me a great pleasure, and it is a great treat, because we do not always have appearing before the subcommittee the elected representative of the people of Samoa, from the Pacific.

He is the former Lieutenant Governor of Samoa. Today, he serves as the delegate from Samoa.

I am pleased to have with us the Honorable Eni Faleomavaega.

Mr. FALEOMAVAEGA. Thank you very much, Mr. Chairman, and members of the subcommittee. I appreciate this opportunity to testify before the committee relative to the Department of Labor appropriations for fiscal year 1990 under the Job Training and Partnership Act.

More specifically, Mr. Chairman, I would like to address the needs of native Samoan Americans who reside in the States of Hawaii, California, and Washington.

Through your efforts and leadership, Mr. Chairman, the Federal Government for the first time, to my knowledge, for fiscal year 1989, appropriated Federal funds to provide job training and related assistance programs for native Samoan Americans residing in the States of Hawaii and California.

I would like, on behalf of the people of American Samoa and all the Samoans residing in the United States, to personally express my gratitude to you, Mr. Chairman, for your sensitivity and for all the assistance that you have given us—valuable assistance to the needs of the Samoans here in the United States.

Mr. Chairman, although the native Samoan Americans thus far have not been properly accounted for by the census, the best estimate that we have come up with is at least over 100,000 native Samoan Americans residing outside the territory of American Samoa.

It seems that the majority of the Samoans reside in the States of Hawaii, California, and Washington. As you may be aware, Mr. Chairman, according to the 1980 census, the national per capita income of native Samoan Americans was $3,500. The per capita income of native Samoan Americans living in the State of Hawaii at the time was about $2,700, which was far less than any ethnic group surveyed.

Without a doubt, low income and high unemployment rates are closely related. It is quite simple, Mr. Chairman: Samoan families, on the average, throughout the United States, live on welfare and in dire poverty.

Mr. Chairman, in 1985 Mrs. Pat Luce, executive director of the National Office of Samoan Affairs, outlined before the House Subcommittee on Employment Opportunities some very critical statistical data concerning the plight of native American Samoans who live in the United States.

Let me just share with you some of these data. About 27.5 percent of native Samoan Americans live at poverty level, below the poverty level, as opposed to 9.6 percent of the total U.S. population: 35.7 percent of native Samoan Americans in Hawaii live in poverty level, as opposed to 7.8 percent of the total State population; 21 percent of native Samoan Americans in California live below poverty level, as opposed to 8.7 of that State's total population; and 10.2 percent of native American Samoans in Hawaii were unemployed, which is twice the data of the State rate at that time. It is common knowledge, Mr. Chairman, that native Samoan American adults work at the most menial jobs available.

Mr. Chairman, of all the minority groups in the United States, the native Samoan Americans suffer the most economically. Indeed, these problems are due primarily to educational, cultural, and language barriers which can be overcome through targeted education and training programs, such as those provided under the Job Training Partnership Program Act.

As you have heard from Ms. Kilali Alailima, she has demonstrated quite ably the situation and the plight of the native Samoans living in the State of Hawaii.

As you can see also from the statement that I will submit for the record by Mrs. Pat Luce, the $2.5 million that was appropriated as a line item for fiscal year 1989 are being used very effectively to support job training programs for native Samoan Americans and other minorities in the State of Hawaii and California.

Mr. Chairman, I am requesting an increase of $1 million for the above programs for fiscal year 1990. These funds will be used to maintain ongoing programs in Hawaii and California and to hopefully establish an additional program in the State of Washington.

As requested by Mrs. Pat Luce and Mr. Frank Peters, representing the Samoan community in the State of Washington, I submit for the chairman of the committee their statements to be made part of the record.

Mr. Chairman, this concludes my statement, and again, I want to express my appreciation again to you for all the years and the tremendous support that you have rendered for the needs of the Samoan communities in the United States, and also in the State of Hawaii.

Thank you very much.

Senator INOUYE. I thank you very much, Congressman.

Your statistics are just horrendous. How do they compare with statistics in Samoa?

Mr. FALEOMAVAEGA. Mr. Chairman, it does not—I think we are a little better off in American Samoa. But the most difficult situation, as it is, I suppose,—you cannot say we are foreign immigrants, because we are U.S. nationals. We have that distinction again of being somewhat separated from the mainstream of America, to the extent that as U.S. nationals, we are neither citizens nor aliens.

We owe permanent allegiance to the United States, and because of the strong cultural ties with the families, when they do leave the territory, they are under tremendous cultural shock. It is true, I suppose, if I were to make a comparison, Mr. Chairman, it is very similar to the native American Indians, and also the plight of my cousins, the native Hawaiians.

Senator INOUYE. Well, I shall most certainly convey your thoughts to my colleagues on this subcommittee, and I am certain they will respond favorably, sir.

PREPARED STATEMENTS

Mr. FALEOMAVAEGA. Thank you very much, Mr. Chairman.

Senator INOUYE. Thank you.

[The statements follow:]

STATEMENT OF ENI F.H. FALEOMAVAEGA

Mr. Chairman and members of the Subcommittee, I appreciate this opportunity to testify before the Committee relative to the Department of Labor appropriations for fiscal year 1990 under the Job Training and Partnership Act. More specifically, Mr. Chairman, I would like to address the needs of Native Samoan Americans who reside in the states of Hawaii, California, and Washington.

Through your efforts and leadership, the Federal Government for the first time, in fiscal year 1989, appropriated federal funds to provide job training and related assistance programs for Native Samoan Americans residing in Hawaii and California. I want to personally thank you.

Mr. Chairman, although the Native Samoan Americans, thus far, have not been properly accounted for in the census, the best estimate that we have come up with is of over 100,000. It seems that the majority of those Samoans reside in the states of Hawaii, California, and Washington.

As you may be aware, Mr. Chairman, according to the 1980 census, the national per capita income of Native Samoan Americans was $3,573. The per capita income of Native Samoans living in Hawaii at the time was about $2,700, which was far less than any ethnic group surveyed.

Without a doubt low income and high unemployment rates are closely related. It's quite simple, Mr. Chairman, Samoan families on the average, throughout the United States, live on welfare and in poverty.

Mr. Chairman, in 1985, Mrs. Pat Luce, Executive Director of the National Office of Samoan Affairs in California, outlined before the House Subcommittee on Employment Opportunities, some very critical statistical data concerning the plight of Native Samoan Americans who live in the United States.

Let me just share with you some of the 1980 census data:

27.5 percent of Native Samoan Americans lived at poverty level as opposed to 9.6% of the total U.S. population.

37.5 percent of Native Samoan Americans in Hawaii live at poverty level, as opposed to 7.8% of the total state population.

21 percent of Native Samoan Americans in California live at poverty level, as opposed to 8.7% of the total state population.

10.2 percent of unemployed Native Samoan Americans in Hawaii, which was twice the state rate.

It is common knowledge that Native Samoan Americans adults work at the most menial jobs available.

Mr. Chairman, of all the minority groups in the United States, the Native Samoan Americans suffer the most economically. Indeed, these problems are due primarily to educational, cultural, and language barriers, which can be overcome through targeted education and training programs such as those provided under the Job Training Partnership Act Program.

As you will hear from Ms. Kilali Alailima, Director of the Samoan Service Providers Association of Hawaii, the combined efforts of the offices and programs established in Hawaii and California, have already placed many unemployed Native Samoan Americans to positions not subsidized by public funds, even though these offices have been opened four months.

As you can see from the statement made by Mrs. Luce, The $2.5 million appropriated for fiscal year 1989 are being used very effectively to support job training programs for Native Samoan Americans and other minorities in Hawaii and California.

Mr. Chairman, I am requesting an increase of $1 million for the above programs for fiscal year 1990, and for 1991, if we are now operating on a two year funding cycle. These funds will be used to maintain the on-going programs in Hawaii and California and to establish an additional program in the state of Washington.

As requested by Mrs. Luce and Mr. Frank Peters, I submit for the record their statements concerning their community needs in California and in Washington.

This concludes my statement, Mr. Chairman, and I shall be happy to respond to any questions. Thank you.

STATEMENT OF PAT H. LUCE, EXECUTIVE DIRECTOR, NATIONAL OFFICE OF SAMOAN AFFAIRS

INTRODUCTION

Senator Inouye and Members of the Senate Sub-Committee on Labor, Health and related Agencies, we thank you for this opportunity to submit this testimony on behalf of the native American Samoan Community in the State of California.

It is a special priviledge to have this opportunity to share with you today the very positive experiences, strong support, and deeply felt respect that our Samoan community in California, and the National Office of Samoan Affairs, in particular, has for Senator Inouye. With aloha, we join our brothers and sisters from Hawaii to say "Fa'afetai tele High Talking Chief Fofoga O Samoa." We also want to extend our deepest appreciation to Senators throughout the country for their support of JTPA funds to address the needs of a particularly high risk population.

Today we want to acknowledge your support, share our successes, and request funding for the continuation and expansion of a vital and promising program.

STATUS OF THE SAMOAN JOB TRAINING PROGRAM

In November 1988, the National Office of Samoan Affairs (NOSA) received $454,575 to provide job assistance to workers of native American Samoan ancestry in areas of the state with a large Samoan population. California houses the largest migrant population from American Samoa. There is an estimated number of 90,000 Samoans living in the State of California. Over half of our population in California are affected by chronic unemployment and under-employment. Throughout the Samoan community there is a general lack of basic skills and English language proficiency, and a growing and alarming rate of substance abuse, domestic violence and gang affiliation. San Francisco Unified School District officials report that Samoan youth have the highest drop-out rate in the district. The Los Angelès area has one of the highest per capital participation in gang affiliation from among Samoan youth. What this means is that although Samoans are not represented as a major minority population in California - as Blacks and Hispanics - our youth are seriously over represented in critical areas of social problems.

Due to the urgency and severity of these conditions, we chose not to concentrate our resources and talents in one community, but rather to establish three program sites: in the San Francisco Bay Area, the Los Angeles Basin and the San Diego Area. We hope through additional funding to reach Samoans in high-risk communities such as Sacramento, San Jose, Orange County and San Mateo.

The Samoan JTPA Program in California is known as "The Native American Samoan Employment and Training Program" (NASETP).

We are happy to report that NASETP has begun to address with considerable success in 4 months of operation the establishment of three (3) program sites. This success can also be credited to support from local community leadership in all three (3) program sites (San Francisco Bay Area, Los Angeles Basin, San Diego Area). Each of the sites offer classroom occupational training, classroom remediation and pre-employment training, on-the-job training and hands-on training in addition to supportive services.

Within four (4) months, 150 participants have been served in California representing 40% of our annual service goal which is 335 participants. Forty (40) participants have been successfully placed in unsubsidized employment, trained eight (8) bi-lingual job counselors and collaborated for participation to include 100 Samoan economically disadvantaged youths in Summer Youth Employment and Training Programs.

Since most of the participants live in low-income, high-crime areas, there is a need to build into the program, in addition to the occupational and job-seeking skills component, training that strengthens self-esteem, offers strategies for dealing with "culture clash," and addresses the problems of gangs and substance abuse.

This program is one of a kind and services a critically needy and underserved population. Our accomplishments thus far demonstrate our strong conviction to promote economic self-sufficiency. Success hinges on the fact that the delivery of services does not depend on government agencies, but rather grassroots organizations working in collaboration with various training and employment agencies such as the State Employment Development Department, Community Colleges, SDA/PIC Apprenticeship Programs, local school districts and private employers.

DISCRIPTION OF THE PROBLEM

Socioeconomic Status of American Samoans:

- The special difficulties faced by American Samoans residing in the United States set them apart from other populations in the United States. They exhibit problems in dimensions beyond those generally associatd with other impoverished populations in the United States. The American Samoans are a relatively small population; however, they have high proportions of persons and families with serious economic disadvantages, according to a 1984 study, by the Northwest Regional Educational Laboratory, commissioned by the U.S. Department of

Labor. Characteristics include: low levels of education, high unemployment, low per capita and household incomes. Less than two-thirds of the American Samoan population in California, 25 years old and over, are high school graduates.

Income is quite low, by any measure. The per capita income for American Samoans residing in the United States is $3,573, according to the 1980 Census, exceeding only that of the Vietnamese. Among American Samoans in California per capita income is about $4,000. Low per capita income is caused by high unemployment rates, employment in low-paying occupations, and high fertility rate; and, it has the consequence that many American Samoan families live in poverty.

The majority of employed American Samoan adults work in occupations that typically pay low wages, frequently at minimum wage. American Samoans are concentrated in service occupations, operators, fabricators, and general laborers. Those American Samoan adults who are more literate in English find employment in clerical and other office occupation. Employment of Native American Samoans in administrative, managerial, professional, or technical occupations are scarce or non-existent in the United States.

American Samoans are a youthful population with a relatively high fertility rate, even among the migrant population in the United States. The median age of American Samoans in the United States is about 19 years. And, the average fertility rate for American Samoan women, upon completing child-bearing years, is over 4 children. The implications are clear: a rapidly increasing population of American Samoans in the United States during the next several decades. Hayes and Levin, in a report submitted with the DOL-commissioned study, estimate that this population could grow to between 84,000 and 182,000, depending on assumed rates of migration and natural increase.

The large family sizes and the low incomes place many American Samoan families below the established poverty levels. According to the 1980 Census, about 21% of American Samoan families in California are below the poverty level, compared with 8.7% of all California families.

Adjustment - A New Enviornment:

- The Samoan Community are well represented in the most depressed areas of the cities. For example, the Los Angeles site's participants include the youths who are members of Samoan youth gangs residing in government housing projects where recruitment is very very difficult. Collaborations with private employers and training facilities have been hindered by the fact that most of our participants have been hindered by the fact tha most of our participants have been stereotyped with these negative labels.

- The Samoan Community is an isolated community. As such, the majority of our clients not only come to us needing work or skill but need a full orientation inacquiring independence in utilizing existing systems such as transportation, communication, job search, and acceptable codes of behavior.

- The area from where most of our participants live is low income and high crime. The environment, added to some drawbacks that are culturally based, are precisely the reasons why Samoans could not access other JTPA programs in their SDA. Support services to assure their certification and continued attendance in training were lacking in those programs. Because JTPA is placement oriented, these "high risk" individuals would have been considered too risky to enroll by other JTPA programs if these individuals were to go to them for training and placement services.

In recognition of the above problems facing our Samoan communities in California, we ask your support and commitment in our struggle to improve and empower our American Samoan families and communities in a movement towards self-sufficiency.

PROPOSED PLAN

The National Office of Samoan Affairs (NOSA), will be funded through 1990 at the present level of $454,575. We are seeking to continue our services through 1991:

California, the state that represents most of the Samoans out-side of the U.S. Territory of American Samoa, has Samoan communities ranging from Northern California to Southern California. Three (3) geographical regions are presently being served: San Francisco Bay Area, Los Angeles Basin and San Diego area. For this program year, we would like to expand service site areas to include: Sacramento, San Jose, San Mateo and Orange County.

We believe the demand for our services is sufficient to serve nearly twice as many people as we are currently serving. In addition to the basic JTPA training and placement, staff efforts are directed to the building of self-esteem and purpose which are key elements in enabling the participant to deal with the "clash" of cultures. Education workshops on the "survival in the U.S." that targets the families coupled with outreach from NASETP staff illustrate to these families how crucial it is to provide support to the participants would definitely have a positive effect and affect on the participants. Additional workshops should address the problem of parents condoning their youngsters "dealing in drugs." The NASETP Program requires staff not only to work with the participant but also with the family. Continuous monitoring and counseling with participants through training, placement and retention is a must. To insure a successful program, additional manpower is required to achieve this.

Samoan JTPA funded programs such as NASETP—which address this specific combination of inadequate educational preparation, limited English proficiency, and non-substantial on-th-job training among American Samoans—are urgently needed. To expand the JTPA services throughout the Samoan communities in California and to ensure that our children, our families and our neighborhoods are able to participate fully in service and programs our government provides. We are seeking funding for a total of 1.25 million dollars for services through 1991.

PROGRAM MANAGEMENT

The Hawaii State Department of Labor, in collaboration with the National Office of Samoan Affairs will continue to be the fiscal agent and provide oversight and monitor the program. NOSA will be developing and managing program operations. This collaborative effort combines the strength of all agencies involved in a way that best insure - the effectiveness of the program.

In closing, we want to thank you for accepting our testimony and again we ask your support for continued funding in recognition of a population at risk. Recommended funding for NASBTP for next fiscal year is 1.25 million dollars for California.

Fa'afetai tele - Thank you.

STATEMENT OF PAT H. LUCE TO SUBCOMMITTEE ON EMPLOYMENT OPPORTUNITIES, COMMITTEE ON EDUCATION AND LABOR, U.S. HOUSE OF REPRESENTATIVES, JUNE 28, 1985

American Samoans, migrating to the United States mainland during the past 25 years, have experienced considerable difficulties in receiving training and employment in the labor market. Major obstacles they face are: limited education, lack of marketable skills, absence of fluency in English, inappropriate cultural expectations about work in a competitive technological society and lack of information on available resources.

According to estimates based on the 1980 Census of the United States, between 40,000 and 50,000 American Samoans (based on the estimated rates of undercount) now live in the United States. Most American Samoans live in California and Hawaii, primarily the Honolulu, Los Angeles-Long Beach, San Francisco-Oakland-San Jose, and San Diego regions.

American Samoans are a relatively small population; however, they have high proportions of persons and families with serious economic disadvantages, according to a 1984 study, by the Northwest Regional Educational Laboratory, commissioned by the U.S. Department of Labor. Characteristics include: low levels of education, high unemployment, low per capita and household incomes.

Less than two-thirds of the American Samoan population in Califonia, 25 years old and over, are high school graduates. The situation is similar in Hawaii, where only about one-half of the American Samoan population (25 years old and over) have completed high school. Compared to other ethnic groups surveyed in the 1980 Census, American Samoans have not only the lowest rate of high school graduation but also the lowest rate of continuation in school by adults 20 years old and over. A disproportionately small number of American Samoans continue their education into post-secondary levels.

Income is quite low, by any measure. The per capita income for American Samoans residing in the United States is $3,573, according to the 1980 Census, exceeding only that of the Vietnamese. Among American Samoans in California per capita income is about $4,000.

Among American Samoans in Hawaii, the per capita income, about $2,700, is less than that of any other ethnic group surveyed. Low per capita income is caused by high unemployment rates, employment in low-paying occupations, and high fertility rate; and, it has the consequence that many American Samoan families live in poverty. The percentage of American Samoans living in poverty in the United States is 27.5 percent compared to 9.6 percent of the total U.S. population. The incidence of extreme poverty for American Samoans is 140 percent higher than for the country.

As at the 1980 Census, the unemployment rate among American Samoans was estimated at 10% a rate of 150 percent of the over-all State unemployment rate of 6.5 percent. Among American Samoans in Hawaii, 10.2% of American adults were unemployed, more than double the rate of the State as a whole.

The majority of employed American Samoan adults work in occupations that typically pay low wages, frequently at minimum wage. American Samoans are concentrated in service occupations, operators, fabricators, and general laborers. Those American Samoan adults who are more literate in English find employment in clerical and other office occupations. Employment of Native American Samoans in administrative, managerial, professional, or technical occupations are scarce or non-existent in the United States.

American Samoans are a youthful population with a relatively high fertility rate, even among the migrant population in the United States. The median age of American Samoans in the United States is about 19 years. And, the average fertility rate for American Samoan women, upon completing child-bearing years, is over 4 children. The implications ar clear: a rapidly increasing population of American Samoans in the United States during the next several decades. Hayes and Levin, in a report submitted with the DOL-commissioned study, estimate that this population could grow to between 84,000 and 182,000, depending on assumed rates of migration and natural increase.

The large family sizes and the low incomes place many American Samoan families below the established poverty levels. According to the 1980 Census, about 21% of American Samoan families in California are below the poverty level, compared with 8.7% of all California families In Hawaii, 37.5% of American Samoan families live below the poverty level, compared with 7.8% of all families.

III. EMPLOYMENT AND JOB TRAINING NEEDS OF AMERICAN SAMOANS

By any measure of eligibility, American Samoans in the United States should be beneficiaries of existing educational and job training programs. Various studies have shown that American Samoan adults encount difficulties in finding and maintaining jobs, because they lack training, job information, and knowledge of how to access resources providing training and employment information. But, American Samoans, in general, do not utilize educational, training, and employment services commensurate with their numbers or needs, according to the DOL-commissioned study.

As it is implemented, the Job Training Partnership Act exists to provide employment and training services to individuals and groups with socioeconomic characteristics such as the American Samoans. How is it that American Samoans have failed to benefit from these programs in proportion to their needs?

The Job Training Partnership Act provides a range of programs (Titles IIA, IIB, and III) for which most Samoans qualify, but few actually benefit. The inability to benefit in proportion to need derives from several sources: the relatively few Samoan organizations available to propose programs to local Private Industry Councils, and the criteria used by PICs in consideration of funding (or, defunding) programs.

The National Office of Samoan Affairs, established in 1976, has, to date, been the only Samoan community-based agency to be successfully funded under the JTPA. At the present time, two programs are funded in the State of California: an ESL (English as a Second Language) occupational classroom training program (funded under 78% Title IIA monies), and a Summer Youth Employment Training Program (funded under Title IIB) monies. The Title IIA program will serve approximately 20 adults over the course of the program year; the SYETP will serve a maximum 60 youths this summer. These numbers are far fewer than the thousand of American Samoan adults and youths, in each urban area in California, who are eligible for JTPA assistance.

Few American Samoans participate in JTPA programs, which are not run by American Samoan agencies. On the one hand, those programs have never made a demonstrated, concerted effort to recruit American Samoan eligibles, when so many other minorities have eligible members. American Samoan communities are comparatively small, and do not seem politically significant when compared to other minorities. On the other hand, those programs do not offer ESL training targeted for American Samoan-speaking adults and youths. Since many American Samoans require language training, in addition to technical training, they cannot easily participate in other programs lacking an Engish/Samoan bilingual training component.

In addition, the sarcity of American Samoan organization makes it difficult to increase the visibility of American Samoan communities, and economic needs, in California and elsewhere. Thus, American Samoans communities have never been successful in their efforts to secure any funding for programs under the 22% JTPA Title IIA monies, allocated at the discretion of the Governor of California and other States.

Criteria used to evaluate funding, and re-funding, of programs under JTPA can actually work against the hard-to-train, hard-to-place person. Placement rates, positive termination rates, and cost per placement (or, positive termination) are several important criteria used by PICs in their evaluation of existing or proposed training program Existing programs will tend not to recruit hard-to-place persons, because the presence of these persons in their programs jeopardizes the ability of that program to meet prescribed placement rates. And, programs which intend to provide services for hard-to-train persons may have, or propose, and unacceptably high cost per placement, as additional training resources and personnel are added to the programs.

As the data indicate, American Samoan communities in the United States have high proportions of hard-to-train, hard-to-place persons. Because of JTPA funding evaluation criteria, this makes American Samoans "high risk" participants in programs sponsored by the general community. And, these same criteria make American Samoan community-sponsored programs "high risk" compared to programs which serve other minorities.

It is for these reasons that the proposed amendments to the Job Training Partership Act are so important to American Samoans in the United States. As proposed by Senator Inouye in S.73, Sections 401(a)(1), 401(c)(1)(B), and 401(h)(1) of the Job Training Partnership Act will be amended to include provisions authorizing programs for American Samoans. Similar amendments appear concurrently before the House. These amendments will afford American Samoans an equal opportunity for benefitting from the JTPA in proportion to their needs.

The proposed amendments will remove the political barriers which have prevented greater participation of JTPA American Samoan eligibles. The fact that the American Samoan population is small compared to other groups competing for limited JTPA funds will cease to be a reason that JTPA fails to benefit American Samoans.

The proposed amendments are consistent with the historical precedents, of the United States government, designed to protect the people of American Samoa. American Samoans are legally recognized as nationals of the United States, and authority over American Samoa is vested in the President of the United States. With more American Samoans living in the United States than live in American Samoa, the Government of the United States, through these amendments, will extend statutory recognition to American Samoans who have migrated from American Samoa.

Most importantly, the amended Job Training Partnership Act will be an important step in addressing the needs of a group with documented and training needs. American Samoans face significant disadvantages in the urban labor markets of the United States. Low levels of educational attainment and limited English language proficiency contribute to this disadvantage; employment in low-level occupations, which offer little substantial on-the-job training, compounds the disadvantages.

JTPA funded programs--which address this specific combination of inadequate educational preparation, limited English proficiency, and non-substantial on-the-job training among American Samoans--are urgently needed. Technical staff, knowledgeable of the unique labor market situation of American Samoans, have not yet been trained. And, the few JTPA funded programs for American Samoans are grossly inadequate for the scope of the problem.

With a burgeoning American Samoan population, increasingly large numbers of American Samoans with employment and training needs will never receive adequate service, unless action is taken now. The proposed amendments to the Job Training Partnership Act will provide a stable funding source, and technically specific programs, required for employment and training services delivery to American Samoans in the United States.

We believe that there is a strong underlying basis to support the contention that a special trust relationship exists between the United States Government and the American Samoans. Based upon similar criteria, such a relationship was found to be present in regard to the Federal Government and the Indian Tribes, Alaskan Natives and Native Hawaiian.

LETTER FROM FRANK A. PETERS, EXECUTIVE DIRECTOR, AMERICAN PACIFIC CENTER

May 2, 1989

The Honorable Daniel Inouye
United States Senate
Washington, D.C. 20510

Dear Senator Inouye:

On behalf of the Samoan community in Washington State, I am writing to commend you and express our appreciation for your wholehearted support of our Samoan people in Washington State. The main purpose of this letter is to call your attention to some of the most critical needs confronting the Samoan people in this area.

As an Employment Specialist for over five years I am acutely aware that employment opportunities for our people is our most critical need. During my years with Employment Opportunities Center I have had hundreds of clients, only five of whom had received a BA degree. My estimate of the average level of education of my clients is the eighth grade.

Samoan parents in Washington State, by culture, continue to emphasize the importance of education to their children. As you may know, education is compulsory in American Samoa. However, the question arises as to how a Samoan parent can encourage their children to pursue higher education or to attend university while the family is dependent on public assistance, food stamps and other social services for their day to day existence.

As you know, employment is a reflection of a person's education. The socio-economic difficulty within our population in Washington State stems directly from the lack of education. With your permission I will briefly summarize the three major areas of most concern in our community.

Employment/Education

Unemployment and the inability to obtain challenging, high paying jobs are considered to be the most significant problems. The Washington State Department of Employment Security does not have statistics that show unemployment among the Samoan population, however, the community leaders feel that the unemployment rate is roughly 50 percent. In a study conducted by the Central Area Motivation Project there were 238 adults in the households surveyed and of these only 96 held full-time jobs. This means that, on the average, each wage earner supports five people with his/her income. Most of the Samoan workers hold unskilled or semi-skilled jobs (such as mill workers, lumber yards and garment factories). According to the CAMP survey, in 10.49 percent of Samoan households, all of the adults were unemployed.

The high rate of unemployment and underemployment among Samoan people appears to be dure primarily to low basic skill levels in the English language and to a lack of training in marketable job skills. In the CAMP survey, the average length of education for the heads of households was less than 8.5 years and more than 75 percent said they spoke English poorly or not at all. In an environment where even low skill jobs require competence in reading, writing and communication the lack of skill in the English language is a serious handicap.

Many Samoans, especially those who are older or have just recently arrived from Samoa lack knowledge of how to look for work and how to apply for a job. They are unfamiliar with where to find job listings or where to find assistance with their job search. Many Samoans do not have skill or experience in writing a resume, filling out job applications or being interviewed by potential employers. Samoan people most often rely on family members to contact them with available jobs.

In addition to employment and education problems experienced by the Samoan community housing, health, job training, language, cultural barriers and unity within the community have been for many years a critical concern among the Samoan community leaders.

Housing

Like other low income groups, many members of Washington State Samoan communities have a hard time finding adequate, affordable housing. However, certain aspects of Samoan make it more difficult to find adequate housing for our people than for other ethnic groups. Because Samoans live in households that are on the average 3.5 times larger than the average Seattle household, they have a need for larger houses or apartments. The number of family size dwellings in Seattle is diminishing. The large dwellings that remain available to Samoan families are older, tend to be less energy efficient, and are in greater need of repairs. A recent study indicated that there were 55 Samoan families in public housing, with additional families on the waiting list.

Health

People in Seattle's Samoan community are not receiving an optimum level of health care. Public health nurses at community clinics report that they see a higher incidence of strep throat, heart problems and kidney disorders among the Samoan patients than among other patients.

Samoan people are limited in their access to good health care by many factors. Being low income many Samoan families simply cannot afford good care from private doctors or hospitals. Lack of transportation limits ready access to facilities and lack of adequate English skills also creates major difficulties. A large number of Samoan families are simply unaware of what health care services are available.

Job Training

In addition to having low English language skills, many Samoan people lack specific job skills that would increase the level of their employment. Because there is so little industry in American Samoa and because government is operated through family structure at the village level, people raised in Samoan are not trained for or even exposed to many of the jobs that need to be done in a modern, industrial country. Samoan leaders in this area are unanimous in recognizing the need for more vocational training and career guidance for all members of the Samoan community, young and old.

Language and Cultural Barriers

Differences in language and culture between the United States and Samoa are principle contributing factors to every one of the problems facing the members of Seattle's Samoan community. Difficulty with the English language restricts the ability of Samoan people to get skilled jobs, to be successful in school, to receive services to which they are entitled, and to gain information about American society that could be helpful. Most members of the community do not take advantage of the English-as-a-second language classes that are available because the classes are not specifically oriented to teaching Samoan people and the teachers do not speak the Samoan language.

Unity

Virtually every Samoan community leader considered the lack of unity within the community to be a serious problem to the community as a whole. Without unity, the community cannot effectively work together to solve the problems common to Samoan people and cannot effectively convince elected officials, agency staff, or employers to be more responsive to Samoan needs.

The American Pacific Center was formed in 1988 by concerned leaders of the Samoan community. The main focus of the APC is to improve and assist the community with meeting the challenges and problems outlined above. We actively seek the challenge of working with our Samoan community to improve the socio-economic status of all members of our community through employment and education.

In closing, I would like to thank you again for your wholehearted support for our Samoan community in Washington State.

Sincerely,

Frank A. Peters
Executive Director

Mr. AKAKA. Congressman Faleomavaega, it is good to have you with us here as a Member of the House.

I was very interested in the statistics you mentioned, which will, I am sure, result in a program for the Samoans.

Presently, is there something in the House that is requesting this kind of help?

Mr. FALEOMAVAEGA. That is correct, Congressman Akaka. I have made the appropriate communications with the senior ranking Member of the House, Congressman Conti, and also Congressman Stokes and several members of the Subcommittee on Labor, HHS, and Education.

So, that is forthcoming, and I am very encouraged that they are supportive of what we are trying to do here.

Mr. AKAKA. I want to take the opportunity to tell you that you can certainly add me on to that list of supporters for your program.

Mr. FALEOMAVAEGA. I really appreciate this, Congressman Akaka. I know that the very difficult situation—it seems that with a population less than 1 percent of the State of Hawaii, the Samoan community, with so much of the visibility and publicity, because we have so many Samoans playing professional football—there are hardly any real appreciation or understanding of the difficulties that many of the Samoan families face when they move to America.

Not taking anything away from the other minority groups, but the problem here is that we are at the lowest—below even the bottom of the barrel, Congressman.

I make this plea with the distinguished Senator and to you, also, as a member of the House Appropriations Committee. This is the first time that we have ever had some kind of appropriation to provide some kind of a training and orientation program for the needs of the native American Samoans who reside in Hawaii and the continental United States.

I attribute this especially to you, Senator Inouye, for your help through all these years, that we finally have got something going here for the first time. I really appreciate this.

Senator INOUYE. Thank you very much.

Mr. FALEOMAVAEGA. Thank you, sir.

Senator INOUYE. We will stand in recess for 5 minutes, and our next witness will be Dr. Sharon Miyashiro.

I will be back in 5 minutes.

[A brief recess was taken.]

STATEMENT OF DR. SHARON MIYASHIRO, DEPUTY DIRECTOR, DEPARTMENT OF LABOR, STATE OF HAWAII

Senator **Inouye**. Our next witness is the distinguished deputy director of the Department of Labor of the State of Hawaii, Dr. Sharon Miyashiro.

Ms. **Miyashiro**. Good morning, Mr. Chairman. Thank you, and thank you for giving us the opportunity to update you on the department's efforts providing special assistance to immigrants and others who have multiple barriers in becoming and remaining employed.

I would like to summarize some of the testimony that has been submitted to you, to highlight the two initiatives of the department—the job help store and the employment service job bank system.

Mr. Chairman, last year I testified on the twofold dilemma facing us in Hawaii: The increasingly critical labor shortage on the one hand, and the need for highly skilled workers for our growing industries on the other.

Then, as now, we believe that the job help store will address this problem by increasing the employability and skills of immigrants and others who have been only marginally linked to our work force.

The State and the people of Hawaii are most grateful that you responded to our needs in such a concerned way. In fact, during this past session, the Hawaii State Legislature focused on the multiple problems facing our immigrants, and we are very pleased to hear of your concern and your support.

They fully endorsed our work, and are anxiously awaiting the results of this program.

As you know, we will start implementing the first year of the job help project this coming July 1. We have begun to locate sites in the high employment growth areas of west Hawaii and west Oahu. We have also worked out service commitments with educational, human service, and other employment and training agencies.

However, we have not proceeded as quickly as we would have liked. One problem has been the allocation of funds under the Job Training Program of the USDOL's Employment and Training Administration. Since there are no guidelines for special projects such as ours, ETA has had some difficulty in determining the applicable administrative procedures to be used.

We believe the current JTPA cost limitations in administration and on support services are too restrictive for the service delivery model we envision. To be truly effective in assisting these underserved groups, and becoming fully employed, we envision the job help store to place significant effort on maximizing recruitment and outreach through bilingual workers, on locating community-based sites where all needed services are coordinated, and if possible, co-located for easy access, on case management and support for each individual, and on linking with and supplementing available employment and training resources, provided by the local service delivery areas and by other State agencies.

In my testimony last year, I emphasized that immigrants from the American Pacific, the Philippines, and Asia, and the resident marginally employable will greatly help to ameliorate the current labor shortage in Hawaii. The labor shortage has become even more severe for us.

We feel the job help store must be able to service all immigrants and refugees. Unfortunately, the legislation adopted last year restricted funding to servicing American Samoans.

While as Ms. Alailima has stated, we have begun on the Samoan project, we believe that the other important half of the equation—recruiting, training, and placing other immigrants—must also be added.

By leaving out these significant groups of potential workers, we will not only reduce the impact of the overall budgeted effort, but we will fall short of dealing with our current labor shortage problem.

Let me point out that immigrants are generally motivated to attain economic self-sufficiency, and are faced with monumental barriers to full employment opportunities. The full range of these opportunities is severely constrained by language and cultural barriers, lack of basic competency and employability skills, and the lack of transferable job skills.

Our primary objective in the job help store is to create a central but flexible locus which can address these special needs of refugee and immigrant families through a continuum of services which is more fully described in my written testimony.

We request the second year funding today to expand this job help store, to reach the remaining two islands of Kawaii and Maui.

Each of these counties is also experiencing severe labor shortages which are expected to continue through the year 2000. Because each island has different needs and conditions, we must develop a flexible approach. But each store will have a common theme—easy access to a wide variety of services and appropriate linkages to meet the unique needs of the individual.

Statewide coordination of resources is assured through the Governor's subcabinet task force on human services and resources, which includes the Departments of Health, Human Services, Education, and Labor.

We have already in operation a model community-based working partnership in east Hawaii, and are working to form similar programs in—I'm sorry, we have a partnership right now in west Hawaii, in Konat, and we will be developing one in east Hawaii, in Hilo, and also on Oahu.

To fully implement this project statewide for the second year, we are requesting $1.7 million.

The second initiative I would like to discuss is the employment service automation and State job bank system. Last year, I reported that our department required help on automating our job matching service, being one of the few States which did not have on-line automation.

Since then, several developments have occurred which compel us to return to seek funding assistance. We have made an earnest attempt to catch up with the rest of the Nation, and have been able to obtain some State funding to lease the equipment we need.

However, we need additional resources to make this system fully operational. We are far from the State job bank system envisioned in the Omnibus Trade and Competitiveness Act of 1988. To enable us to have a truly efficient and effective system to meet the needs of both employees and employers will require the following: First, the child care resource data bank. We have data to indicate that 28,000 parents say that they would work at least part-time if they had access to child care; second, to interface with our unemployment insurance program; third, mobile units to make the system available in remote areas of the State; and finally, to link with the Hawaii State Occupational Coordinating Committee, which is a multiagency committee, to enable us to conduct analyses of trends in labor supply and demand and other critical employment-related issues, so that we can in fact develop our human resources to meet the State's economic development pursuits.

To develop and implement a cost-effective system, including the necessary data bases and interfaces, would require $1.2 million over the next 2 years.

Mr. Chairman. these employment projects will assist Hawaii in meeting the many challenges facing us, assisting our diverse immigrant and refugee populations to overcome the multiple employment related barriers facing them, overcoming our current and anticipated work force shortages, and assisting employers in linking with skilled employees to compete internationally.

With your continued support, we are confident that we can successfully meet these challenges.

Thank you very much for your support.

Senator **Inouye**. I thank you very much, Dr. Miyashiro.

I believe the record should state that the State of Hawaii, because of its central location in the Pacific Ocean, because of its climatic conditions, and because of its ethnic composition, has become the most favored location for refugees and immigrants from Asia, Southeast Asia, and the Pacific area.

And as such, we have become the home of the largest number of refugees and immigrants from that part of the world. I believe the U.S. Government has some responsibility for this disproportionate number of refugees in our State. After all, it is the policy of this country—it is not the policy of the State—that brought about the refugees in Hawaii.

I can assure you that that fact will be made known to the members of this committee, and I hope that they too will look upon this matter as a matter of Federal obligation and Federal responsibility.

Ms. **Miyashiro**. Thank you very much.

Senator **Inouye**. Did you want to say something?

Mr. **Akaka**. Thank you very much, Mr. Chairman.

Dr. Miyashiro, it is good to have you here in Washington. It is also good to hear your testimony about what Hawaii is doing in the line of your programs of job help store and also the employment services State job bank system.

I must tell you that here in Washington, it is a spice by other members from other States to know that Hawaii has one of the best types of programs in projects that they decide to do in Hawaii.

I want to tell you that Hawaii and the State of Hawaii has a good reputation, and knowing that reputation, I know this is working well, and you are deserving in being considered for the $1.2 million you are looking for.

Thank you very much.

PREPARED STATEMENT

Ms. **Miyashiro**. Thank you very much, Congressman Akaka.
[The statement follows:]

STATEMENT OF SHARON Y. MIYASHIRO

Mr. Chairman, thank you for your continued support of Hawaii's employment and training programs, and for this opportunity to update you on the status of these programs. We are also requesting your assistance once again in two areas: (1) continued funding of the JopHelp Store; and (2) funding for our Job Bank System.

JobHelp Store

Mr. Chairman, last year I appeared before this body to address a critical employment problem facing Hawaii--the problem of the severely unemployed, underemployed, and disadvantaged recent immigrant and the marginally employable resident. The State and people of Hawaii are most grateful that the Senate of the United States responded to our needs in such a concerned way, appropriating funds necessary to begin dealing with these multiple problems.

As you know, we will start implementation of the first year of the JobHelp Store project on July 1st of this year. Site plans for locating the JobHelp Stores in high employment growth areas (West Hawaii and West Oahu) are in final form, and we have also worked out service commitments with educational, human services, and other employment and training agencies. However, we have not proceeded as quickly as we would have liked.

One problem has been in the allocation of funds under the job training program of the Employment and Training Administration of the U.S. Department of Labor (ETA). Since there were no guidelines for special projects such as the JobHelp Store, we have had some difficulty in working with the ETA to clarify the applicable administrative procedures.

Limiting the activities of the JobHelp Store to those contained under the Job Training Partnership Act (JTPA) clearly would impede the innovative outreach and service delivery activities that are required to bring these underserved target groups to needed services.

The JobHelp Store is a bit of a different animal. It is an innovative attempt to maximize recruitment and outreach of job trainees and to create a coordinative, consolidated, community-based facility. Normally, JTPA requires that program funds be used for training, an understandable position. However, this requirement is restrictive for the JobHelp Store, where significant effort will go toward recruitment, outreach, and appropriate local facilities, and where the intent is to link with and supplement available training resources provided by the State's SDAs. We estimate that 77% of the operating budget must be used for non-training activities (32% for trainee support and 45% for job counseling/placement staff support).

In my testimony last year, I emphasized that both recent immigrants and the resident marginally employable are the target groups which we see as greatly helping to ameliorate the current labor shortage in Hawaii. And the labor shortage is becoming even more severe for us. Because we are an island state, we are not able to recruit needed employees from our sister states. Some employers in desperation are looking at Pacific and Asian countries as possible sources. Thus, we feel the JobHelp Store is even more critically needed. We must deal with the language and cultural barriers of the Pacific Island and Asian immigrants and the basic skill deficiencies of residents who have not traditionally participated in work. Unfortunately, the legislation adopted last year restricted funding to servicing American Samoans.

We believe that the other important half of the equation--recruiting, training and placing other immigrants and the marginally employable--must also be added. This shortcoming in the wording of the legislation precludes the USDOL from allowing us to serve these target groups, and will significantly reduce the impact of the overall budgeted effort. It simply will not be possible to deal with the current labor shortage by leaving out this significantly large group of potential job trainees. Ex-felons, women in transition, employable welfare clients, some of the homeless, salvageable teens, and the handicapped should also benefit from these services.

Let me point out that immigrants are generally motivated to attain economic self-sufficiency, but are faced with monumental barriers to full employment opportunities. Among Asian immigrants, recent arrivals are characterized by occupational and income levels far below what would be expected, given their educational levels. Longer residence appears to result in jobs which are considerably below their educational levels (doctors working as orderlies, teachers as maids). Many Pacific Basin immigrants participate in the labor force and are heavily concentrated in service and farming occupations. Their access to full employment opportunities are severely constrained by language and cultural barriers, lack of basic competency and employability skills, and lack of transferable job skills, as in the case of underemployed foreign-trained professionals.

Our primary objective is to create a central but flexible locus which can address the special employability information and placement conditions facing recent refugee and immigrant families. Both youth and adults in this population group have a wide range of English language deficiencies, general educational development and job skill gaps, as well as cultural and social adjustment problems. The combination of cultural and adolescent adjustment presents a special concern as does intergenerational conflict. Basic skills, career information, cultural awareness, transition into the world of work, apprenticeship and other training options, and postsecondary training preparation programs to meet the needs of these groups can be met best through a cost-effective centrally-integrated delivery of a continuum of all these services.

The labor exchange process needs improvement by increasing and facilitating the outreach, registration, and servicing of all levels and types of jobseekers and potential jobseekers at a time of current and projected worker shortages. A model "clearinghouse" for employment and training programs in the community is needed. Included in this need is the delivery of employment and training information as well as developing an awareness of worker rights, benefits, and responsibilities.

Our JobHelp Store is to be a "clearinghouse" of services which will test the effectiveness of a central, easily-accessed and coordinated delivery system. Rather than being the sole proprietary of one employment program, it is a consortium of services under one non-institutional roof in a non-bureacratic setting managed by the Department of Labor and Industrial Relations (DLIR). The requested second year funding will enable us to locate the JobHelp Store on each of the four major islands in the state. Each of these counties is experiencing severe labor shortages which are expected to continue through the year 2000. The stores will be staffed by professionals from several program areas within the Department and from outside. Services are focussed on the immigrant and the marginally employable and include public information, outreach, intake, employability development (vocational assessment and training), job placement, and employer assistance. Flexibility of approach will allow easy access to a wide variety of services, as well as appropriate linkages to meet the unique needs of the individual. In addition, coordination of resources is assured through the Governor's Sub-cabinet Task Force on Human Services and Resources (which includes the Departments of Health, of Human Resources, of Education as well as of Labor). Such support will facilitate direct referrals for supportive services should they be needed to enable the person to fulfill his or her potential.

To fully implement this important project statewide for the second year will require $1.7 million.

Employment Service Automation/State Job Bank System

Last year I reported that our department required help automating our job matching service. We were manually handling over 130,000 service transactions to approximately 80,000 persons statewide. We were one of the few states which did not have online automation. Since then several developments have occurred which compel us to return to seek funding assistance.

We have made an earnest attempt to catch up with the rest of the nation. This has been a priority for us, and we have been seeking funding assistance. We have been able to obtain some state assistance to lease the equipment needed. However, additional resources are necessary to make the system fully operational. We are far from the state job bank system envisioned in the Omnibus Trade and Competitiveness Act of 1988 (see Section 6307 of PL100-418). To enable us to have a truly efficient and effective system to meet the needs of both employees and employers of our state, we will require the following: (1) A child care resource data bank will help us recruit some of the 28,000 parents who say they would work at least part-time if they had access to child care. This is a tremendous resource pool which should be included in our Job Bank system. (2) Additionally, we want to interface with our Unemployment Insurance Program to improve our servicing of unemployed claimants, providing them with earlier and more appropriate placements. (3) We also want to make the system available to remote locations in the State to enhance our recruitment efforts. (4) We also need to link with the Hawaii State Occupational Information Coordinating Committee (SOICC), a multi-agency committee comprised of agencies dealing with economic development that need occupational supply/demand data to attract new employers and new jobs; JTPA service delivery agencies that use these data to determine job training openings; and educational institutions at all levels. Through this linkage, the SOICC will be able to conduct the occupational analysis of trends, special economic impact areas, and critical issues so that we can meet the challenge facing us: ensuring the development of our human resources to meet the State's economic development pursuits.

Automation of Hawaii's job matching system will give us a major tool for servicing employers facing the labor shortage as well as helping needy job seekers. To develop and implement a cost-effective system with the necessary data bases and interfaces outlined above, $1.2 million over the next two years will be required.

CONCLUSION

Mr. Chairman and members of the Committee, these employment projects will assist Hawaii in meeting the many challenges facing us: assisting our diverse immigrants and marginally employable; overcoming the current and anticipated workforce shortages; and linking employers with skilled employees so as to compete successfully in the global economy. With your continued support of our efforts, we hope to successfully meet these challenges.

STATEMENT OF MYRON THOMPSON, TRUSTEE, BISHOP ESTATE

ACCOMPANIED BY:

THOMAS KAULUKUKUI, PRESIDENT AND CHAIRMAN, CHIEF EXECUTIVE OFFICER, BISHOP ESTATE

E. KANANI MARIANO, CHIEF EXECUTIVE OFFICER, OFFICE OF HAWAIIAN AFFAIRS

DR. SATORU IZUTSU, UNIVERSITY OF HAWAII MEDICAL SCHOOL, KUAKINI MEDICAL CENTER

SHERYL FRANKLIN, BISHOP ESTATE

HAVNANI APOLIONA, ALU LIKE, INC.

RICHARD PAGLINAWAN, EXECUTIVE DIRECTOR, OFFICE OF HAWAIIAN AFFAIRS

BOB SPRINGER, KAMEHAMEHA SCHOOLS

BRIAN MARTIN, E OLA MAU

Senator INOUYE. Next we have a panel consisting of the very distinguished trustee of the Bishop Estate, Myron Thompson, Thomas Kaulukukui, the new president and chairman, chief executive officer of OHA, the Office of Hawaiian Affairs, and E. Kanani Mariano.

Accompanying this panel are the following, who have traveled long distances to be with us and assist us in this activity: Dr. Satoru Izutsu, of the Kuakini Medical Center; Sheryl Franklin of the Bishop Estate; Havnani Apoliona, of Alu Like, a major native Hawaiian organization; executive director of OHA, Richard Paglinawan; Bob Springer, of Kamehameha Schools, and Mr. Brian Martin of E Ola Mau.

Why do you not all come forward and sit down with these people and get on television?

You do not mind sharing the lights with these people, do you?

Mr. THOMPSON. Mr. Chairman, I feel a lot more secure with their support around us.

At this time, I would like to say good morning, Mr. Chairman.

I echo Congressman Akaka's sentiments regarding your untiring concern for the well-being of all native Americans.

For the record, my name is Myron Thompson. I am a trustee of the Kamehameha Schools. I am here for three reasons: First, to thank you for your concern; second, to report on programs that you have supported; and third, to share with you some of our future plans.

Let me summarize accomplishments made possible by you last year. Vocational education programs reached 2,100 Hawaiians. Also, you supported library services through which books and parent workshops were carried to all parts of Hawaii, remote rural sections as well as needy urban centers.

Family-based educational centers serviced a total of some 1,200 children and their parents. We were privileged to have one of your staff visit us, Mr. Roga, who visited one of our traveling pre-schools and the activities for the 2- and 3-year-olds.

He can attest to the involvement and learning of these participants.

I thank you also for support of a 2-year hearing grant. This project began this week.

In addition, development of the Native Hawaiian Mental Health Research Center is underway.

Mr. Chairman, your legislation is making a difference. Public Laws 100-297 and 100-713 will allow us to make further progress in getting Hawaiians as a group at least to parity with national averages.

This is a common goal of numerous agencies such as the Office of Hawaiian Affairs and Papa Ola Lokahi.

Now, let me turn to the future and to those programs for which funding by your committee is critical.

Our highest priority is continued support for family-based educational centers. This is consistent with national concerns. We are requesting appropriations at the authorized level of $2.4 million.

Please note that there are others addressing this need, including the University of Hawaii at Hilo, in cooperation with the National Center for Nursing Research.

Our second priority is to obtain financial aid for higher education. Hawaiians remain underrepresented in this area. Aid to students in postsecondary programs will make a difference.

This reminds me of the GI bill of World War II, which dramatically changed the lives of hundreds of young men in Hawaii.

I am one of them, along with many of our Nation's leaders of today, including yourself, Senator Inouye.

Like a large number of Hawaiian students today, you and I were first generation college attendees, and without the GI bill, some of us would not have succeeded.

Now, on our final priority, financial aid for health careers. Here, too, there is underrepresentation of native Hawaiians preparing for health professions. For example, while Hawaiians comprise some 20 percent of the State's population, only 2.5 percent of the enrollees in the University of Hawaii's School of Public Health are native Hawaiians.

We need more native Hawaiian health professionals. Funding at the authorized level of $1.8 million is requested.

Senator Inouye, thank you for this opportunity to appear before your committee.

PREPARED STATEMENT

Allow me to make one more comment. We do not wish to come before you any longer than is necessary to achieve our goals—namely, educational parity and self-sufficiency for Hawaiians. I also extend our support to Congressman Hawkins' request, and with your assistance, we feel this will come soon.

Senator INOUYE. Thank you very much, Mr. Thompson.

[The statement follows:]

STATEMENT OF MYRON THOMPSON

Good Morning Mr. Chairman and members of the committee. My name is Myron Thompson. I am a trustee of the Kamehameha Schools/Bishop Estate, an educational institution in Honolulu, Hawai'i, established in 1887 for the purpose of educating Native Hawaiian children. I am here today to thank you for your continued concern about the educational status of Native Hawaiian children; to report on progress of programs you have so generously supported; and to tell you of needs and plans for the future.

THIS COMMITTEE HAS BEEN INSTRUMENTAL IN ASSISTING NATIVE HAWAIIANS IN THEIR EFFORTS TO REACH PARITY

For more than eight years, your committee has been concerned about the severe condition of Native Hawaiians. You ensured that educational needs were clearly documented; comprehensive plans developed; programs instituted; and, finally, progress made.

We appreciate the efforts of this committee and thank you sincerely.

THE IMPACT OF THE NATIVE HAWAIIAN EDUCATIONAL ASSESSMENT IS STILL BEING FELT

The Native Hawaiian Educational Assessment Project, updated annually, was mandated by this committee in 1981 and funded and prepared by Kamehameha Schools. It continues to provide guidance for the authorization of programs addressing Native Hawaiian education.

Shortly after its presentation to committee in 1984, specific funds in vocational education, library services, and early childhood education were made available for Native Hawaiians. Let me briefly update you on the progress of these programs.

APPROPRIATIONS HAVE BROUGHT GREAT IMPROVEMENTS

Last year the committee's funding for Native Hawaiian Vocational Education programs provided 17 projects, working with 2,100 Native Hawaiians.

In Library Services, over 50,000 Native Hawaiians participated in programs on all islands, ranging from parent workshops enhancing parents' ability to utilize libraries with their children to a bookmobile that provided library services to remote Hawaiian Homestead communities.

In early childhood education, you provided the capability to make broad gains in two major areas: direct service for additional children and data management. Both are critical to early childhood efforts in Hawai'i and nationwide.

You have sufficient data speaking to the merits of early childhood education, thus justifying increased direct service. Now, we and others who provide early childhood education need to determine what the characteristics of the most successful programs are, particularly those which have long-term impact on a child's subsequent educational achievement and social and economic status as adults.

In direct service, we were able to serve 600 more Native Hawaiian children and families in Family-Based Education Centers (FBEC's). When fully operational, an FBEC contains the following components: 1) pre-natal/peri-natal education programs for parents and infants, traveling preschool programs for 3-4 year olds, and center-based preschool programs for 4-5 year olds.

Our most exciting component, the Traveling Preschool, is bursting at the seams in the O'ahu community of Wai'anae, where, since its inception last spring, twice a week, some 50 to 60 young children and their parents or caretakers participated in educational activities at local community centers and parks where the preschool is taken. One of your staff members visited a traveling preschool at a local park and can attest to the involvement, enthusiasm, and solid participation on the part of these families.

Traveling preschools are cost efficient and accessible; they use existing community facilities that are frequented by families. They effect positive change - requiring the parent or caretaker to remain on site with the children and to participate in educational activities. They reach those who need it. Data from surveys show that the program serves families that otherwise would be without any early education program. Because of the tremendous interest in this program in the community, I have asked staff to double the contact hours with the children and families.

In evaluating our programs, studying others, and matching data with social service agencies, we found that a consistent database was lacking. This is not unusual since the focus on early childhood education is fairly recent. Some use different definitions for at-risk. Many tests with insufficient commmon indicators are given to the children. Medical information requested on children vary. Income level reporting on the part of parents are in different ranges, depending on the agency. This makes it difficult to gauge progress of children or make comparisons between different programs.

Your support has enabled us to match early childhood categories to larger databases, such as the U.S. Census, the State Education System, Business and Economic indices, etc. This allows better long-range tracking of a child, better knowledge of the effect of programs. Now when a child enters our prenatal program as a fetus, 8 years from now and longer we will know what his or her reading scores are if the child still resides in the State of Hawai'i.

I would like to take just one moment to thank the committee again for your support of hearing screening and follow-up programs for Native Hawaiian children. It was through your funding that we established the extremely poor performances of young Hawaiian children in language skills, the high incidence of mild intermittent hearing dysfunction among these children, and the statistically significant relationship between these two phenomena. You have provided for positive change.

Thus, your funding is making a difference, a needed difference in assisting Native Hawaiians to become self-sufficient and full participants in contemporary society.

THE NATIVE HAWAIIAN EDUCATION ACT WILL MAKE AN EVEN GREATER DIFFERENCE

Public Law 100-297 provides five specific programs to address Native Hawaiian education needs. You provided funding for these authorized programs during the Hundredth Congress and Kamehameha Schools is in the process of completing proposals for three of the programs. We look forward to receiving the funding within the next six months.

The programs contained in Public Law 100-297 all fit into the comprehensive master plan of the Kamehameha Educational System.

The Kamehameha Educational System has the mission of assisting Hawaiian children throughout the State of Hawai'i in their efforts to develop their highest potential as effective participants in society by offering as many meaningful educational opportunities as resources will permit. We have a private day and boarding school serving about 3,000 Native Hawaiian children. But more far reaching in nature are our outreach programs which serve the entire state through programs operating in the public school system. The programs in P.L. 100-297 are part of this outreach effort; these programs will not stand alone, unreinforced, unrelated, or without context - they anticipate entry to subsequent programs in the Native Hawaiian student's educational career, reinforce a previous one, or complement existing programs and services, all of which directly contribute to one of Kamehameha Educational System's objectives.

The components of the system are briefly described below.

Families can begin to participate in Kamehameha's Prekindergarten Educational Programs (PREP) as soon as the mother knows she is pregnant, and they can remain in the program until the child enters kindergarten. Although the approach emphasizes education as the focus of social change and family support, the project seeks the cooperation and active involvement of health and social service agencies to provide a coordinated support system for families.

The program consists of three components:

First, during pregnancy and until the child reaches age two, parents are involved in PREP's home visiting component. Second, two and three year olds and their families participate in traveling preschools which provide services right in the community park or church. Third, 4-year-olds attend center-based preschool classrooms. Parts of these programs were described earlier.

The Kamehameha campus in Honolulu provides a home visitor program, traveling preschool, and center-based preschool. For leeward O'ahu, Kamehameha operates a home visitor program, traveling preschool, and center-based preschool in Wai'anae. On windward O'ahu, Kamehameha provides a home visitor program, traveling preschool and a center-based preschool in Kahuku. On the island of Hawai'i, Kamehameha recently established a home visitor program.

Once a student reaches kindergarten, the Kamehameha Elementary Education Program (KEEP) is available. KEEP's goal is to raise the average reading and language arts achievement levels of Native Hawaiian public school children to parity with students nationwide. Key characteristics are an emphasis on the "higher" order of cognitive operations and instructional practices and classroom organization which are compatible with the culture of the students.

KEEP is currently in eight public school sites (grades 1-3). On windward O'ahu, the program is in Hau'ula; on leeward O'ahu in Nanakuli, Wai'anae, and Makaha; on the Island of Hawai'i in Pahoa, Keauhaka, and Kohala; on the island of Kaua'i at Kekaha. We are in the process further developing KEEP, particularly in relation to adjustments needed at various sites. The hope is that successful KEEP projects will someday be in all schools where there are large proportions of Native Hawaiian children.

Other programs in the Kamehameha Educational System which complement these efforts are:

- Intermediate Reading, providing tutoring in reading to underachieving Native Hawaiian children in 10 public intermediate schools;

- Alternative Education, providing services to alienated youth who have dropped out or are at-risk to dropping out of public high schools;

- Continuing Education, providing the opportunity for life-long learning to Native Hawaiians of all ages, offering basic skills for high school equivalency diplomas, Hawaiian cultural studies and lectures, arts, crafts, vocational skills and many other educational activities;

- Hawaiian Studies Institute, ensuring preservation and respect for the Hawaiian culture, language, and people by providing teacher training and other cultural programs throughout the state;

- Summer Programs, operating summer school classes in public schools in areas where there are large numbers of Hawaiian children and which would otherwise be without any summer programs;

- Neighbor Island Resource Centers, providing liaison services from outside islands to the O'ahu based Kamehameha campus;

- and Post-High Scholarship and Counseling Program, assisting Native Hawaiian students who do not attend the Kamehameha Schools in enrolling in, financing, and succeeding in postsecondary education.

. Further complementing these programs are two additional federally funded programs: Talent Search (a TRIO program), and Native Hawaiian Drug-Free Schools and Communities Program. Talent Search assists low-income public schools students in seeking financial aid and in enrolling in postsecondary education programs. The program is in seven schools on O'ahu and five schools on the Island of Hawai'i.

When enacting laws benefitting Native Hawaiians, Congress has stated that ".....the Federal Government retains the legal responsibility to enforce the administration of the State of Hawai'i's public trust responsibility for the betterment of the conditions of Native Hawaiians and that the attainment of educational success is critical to the betterment of the conditions of Native Hawaiians." Thus, we wish to assure you that programs provided by your dollars are integrally linked to Kamehameha's long-range, carefully developed, comprehensive plans for Native Hawaiian education. These plans are further enhanced by numerous cooperative agreements with other agencies and institutions, including the Hawai'i Department of Education and the University of Hawai'i.

With this background, let me now return to those programs for which funding by your committee is critical.

Increased Services in Early Childhood Education Can Be Made Available by Family-Based Education Centers

The needs are still critical. The Native Hawaiian school age population is estimated by the Hawai'i Department of Education to be 36,900 in 1987-88 or 22.2% of the total school age population. Data indicates that the Native Hawaiian population of those under 25 is increasing.

Using these population statistics for comparison, data on Native Hawaiian as an at-risk population can be better described. We find that these risk factors start at birth. Thirty-one percent of all low birthweight babies are Hawaiian, and 42% of all teenage mothers are Hawaiian.

When these children enter school, other risk factors become apparent. Upon entrance to kindergarten, the Hawai'i Department of Education administers the Peabody Picture Vocabulary Test-Revised. The average score for ethnic-Hawaiian children (n=2,870) is at the 13th percentile on the national norm.

Early childhood programs can help. Every new report on early education continues to indicate long-term positive effects.

Your continued funding for Family-Based Education Centers will allow us to serve more economically disadvantaged Native Hawaiian students. This first year of funding, we will concentrate on the establishment of 11 Family-Based Education Centers. In the ensuing years, the number of centers will be increased thereby providing programs to more children and families throughout the state. We expect to serve 400 additional families next year and 570 additional families every year thereafter.

Mr. Chairman, our recent grant proposal for the funds you provided for FY 1989 is for $1,778,400. We ask for an additional $535,000 for FY 1990. I assure you that your funds are an excellent investment in the future of these families and society.

Funding for Family-Based Education Centers along with financial aid in higher education, which will be discussed next, and financial aid in health professions education are our highest priorities.

Financial Aid Programs for Higher Education Will Positively Impact the Next Generation

Hawaiians remain disproportionately under-represented in all campuses of Hawai'i's postsecondary educational institititions. In the fall of 1987, Hawaiian students comprised 9% of the total enrollment in the University of Hawai'i system (four- and two-year schools), and only 5.1% of the student body at the four-year, baccalaureate granting, Manoa campus. This, again, can be compared to the Native Hawaiian school age population of 22.2% estimated by the Hawai'i Department of Education in 1987-88.

In addition, the proportion of Hawaiian students at the postsecondary level decreases as educational level increases: only 2% of the graduate school population at the University of Hawai'i are Native Hawaiian. The data suggests that a complex set of socio-economic factors are related to this under-representation. There are also indications that the educational system itself contains barriers to the enrollment and retention of ethnic minorities. The Sociology Department of the University of Hawai'i recently completed a significant study regarding retention. A general conclusion is that although Hawaiians at the University of Hawai'i, Manoa, appear to be comparable to their peers in overall ability and preparation at the time of entry, they experience more problems academically, take comparatively longer to graduate, and have lower graduation rates than their non-Hawaiian peers.

Interviews with a small group of students reveal that the key problems for many Hawaiian students include an inability to cope with academic requirements; discomfort with the large classes and impersonal qualities of the university setting; and financial constraints that necessitate combining work with school.

The Native Hawaiian Higher Education Demonstration Program's purpose is to further the attainment of educational success among Native Hawaiians by providing fellowships and related services for postsecondary students at undergraduate and graduate levels. The activities of this program will be as follows:

1. Provide full or partial fellowship support for Native Hawaiian students enrolled at an accredited two- or four-year degree granting institution of higher education with awards to be based on academic potential and financial need.

2. Provide counseling and support services for such students receiving fellowship assistance.

3. Provide preparation and guidance counseling at the secondary school level for students who may be eligible for fellowship assistance.

4. Conduct appropriate research and evaluation of program activities.

5. Implement faculty development programs for the improvement and matriculation of Native Hawaiian students.

Mr. Chairman and committee members, I cannot tell you the importance of this program to the Native Hawaiian people. This higher education program reminds me of the G.I. Bill. I know from personal experience, that the G.I. Bill dramatically changed the lives of hundreds of young men in Hawaii. I was one of them, along with an array of extremely successful men today, including your respected colleague, Senator Inouye. We were first generation college attendees, just as the vast majority of our Native Hawaiian students. Without the G.I. Bill, we would not be where we are today. Your assistance with these higher education funds will provide support systems which contribute to retention, graduation, and, most importantly, the development of excellent role models for future generations of successful participants in society. Current funding provided by your committee for FY 1989 is $1,500,000. Funding at the authorized level of $2,000,000 is desirable.

Efforts to Determine the Best Dissemination Models for the Kamehameha Elementary Education Program (KEEP) Can Now Get Underway

The breakthrough several years ago with successful implementation of KEEP in our model schools has been tempered with difficulties in the field sites throughout the state. Your funding will allow us, this year, to begin the systematic investigation of KEEP and examine those variables which affect consistent, successful implementation in the many sites.

As mentioned earlier, KEEP is now in 8 public schools. During the past few years of this program dissemination, KEEP has been positively reviewed by three different panels of nationally and internationally recognized educational experts. Nonetheless, quantitative evidence of KEEP's effectiveness under conditions of widespread dissemination typical for public schools in the State of Hawai'i is currently lacking. In order to provide decision makers in the Hawai'i State Department of Education and Kamehameha Schools with information necessary for justifying wider dissemination of KEEP, there is need to comprehensively evaluate the effects of KEEP on students and teachers.

Thus, it is the focus of our current efforts, with funding from this committee, to join with the Hawai'i Department of Education in a summative evaluation of KEEP. A recent review by the Northwest Regional Educational Laboratory stated that, "Such collaboration will provide for a coordinated focus on substantive issues and a common mission to upgrade what appears to be a potentially great instructional resource to the Hawai'i school system."

KEEP is key to Native Hawaiian children achieving academic parity with the rest of the nation and their peers in Hawai'i. Current funding provided by your committee for FY 1989 is $400,000. In order to continue evaluation efforts, make improvements, and begin planning for dissemination we ask for $450,000 for FY 1990.

YOUR COMMITTEE HAS THE POWER TO MORE FULLY ASSIST NATIVE HAWAIIANS THROUGH THE MULTIPLE PROGRAMS YOU FUND IN OTHER AUTHORIZING LEGISLATION

Health Professions Financial Aid

My colleague will address the dismal health conditions of Native Hawaiians so I need not dwell on those statistics. However, there is need to provide an opportunity for Native Hawaiians to assist their own people in regaining the vitality that this indigenous group once enjoyed. Authorizing legislation in Public Law 100-713 designated Kamehameha Schools to distribute financial aid to Native Hawaiians preparing for careers in health. We ask that you give every consideration for full funding of this program.

Without good health, we cannot teach our children and they cannot learn. And without competent caregivers, including Native Hawaiian caregivers for those who need that special sensitivity, we cannot gain good health.

There is severe under-representation of Native Hawaiians in programs which prepare for careers in health. In Public Health, 2.5% of the enrollees are Native Hawaiian; in Nursing, 4.1%; in Medicine 5.6% (there is an affirmative action program in the School of Medicine). Again, these figures show the disproportionate under-representation when compared to the estimated Native Hawaiian school-age population of 22.2%.

Funding to support financial aid to Native Hawaiians in the health professions education was not provided in the 100th Congress. Authorization of appropriations is $1,800,000. We ask that you give every consideration to funding this authorized program.

Drug-Free Schools and Communities

Native Hawaiian young people, according to the statewide assessment sponsored by the federal government, are the most at-risk to substance abuse. Funding for programs targeting Native Hawaiians began in 1987-88 with cooperation of the Hawai'i Department of Education and their schools in the Leeward District. This effort will continue. Subsequent funding allows for Resource Indentification and Needs Assessment at Kamehameha Schools with preliminary dissemination efforts statewide.

The war on drugs must be won and prevention is key. Your continued support is solicited.

Special Education

This program is authorized under P.L. 100-297, discussed earlier. It will not be operated by Kamehameha Schools and thus I did not address special education along with FBEC's, KEEP and Higher Education financial aid. There is need, however, for continued funding of this program.

Native Hawaiian students continue to be over-represented in special education programs. Most significant is in the learning disabled - 35 percent of all children identified as learning disabled are Native Hawaiian, even though Native Hawaiians only represent 22 percent of the school population.

We believe that this over-representation is due to assessment procedures which inappropriately identify Native Hawaiian children as learning disabled because they exhibit different learning characteristics and do not respond to the same teaching methods as compared to their white and Asian counterparts. Funding will assist in correcting this unfortunate misidentification of our youth.

Funding for FY 1989 was $500,000. Just recently, the Request for Proposals was sent and the Hawai'i State Department of Education is coordinating this effort. Until the proposal is complete, we will not know the funding needs for subsequent years, but your continued support for special education is requested.

Talent Search

For many years, your committee has recognized the need to assist first generation and low income college hopefuls. Several years ago, Kamehameha undertook one of your programs, Talent Search, and began a project which was situated in an area with a high proportion of Native Hawaiians, but which served a variety of ethnicities. We are most pleased with the outcome of these efforts, as are the program consultants from the federal government who review our work. We wish to continue and urge the committee to fund Talent Search nationwide.

Mental Health

Last, but certainly not least, is mental health, an area of critical importance to the well-being of every person, every ethnic group, every nation. As with most other statistics, Native Hawaiians are over-represented in this area. In addition, Native Hawaiians are less likely to seek assistance. Your committee has recognized that the mental health of Native Hawaiians could possibly be more quickly and appropriately improved if solutions were not so alien to the afflicted. We appreciate the funding you have already provided and ask for continuance.

IN CONCLUSION

Chairman Harkin, I sincerely thank you for allowing me to present our information and requests for your consideration. I wish to let you know one more thing. We do not expect to be standing before this committee for very far into the future. Our goal is parity and self-sufficiency. With your assistance, this will occur soon.

STATEMENT OF TOMMY KAULUKUKUI

Senator INOUYE. Now may I call upon our most noble athlete—most people are not aware, but he is the man who set the first 103 yard run, major football team in the United States.

He is now the president of the Office of Hawaiian Affairs, Tommy Kaulukukui.

Mr. KAULUKUKUI. Thank you, sir.

Aloha, Chairman Inouye, and members of the committee. Thank you for the opportunity of testifying before you today, and thank you, too, for your continued support of programs to native Hawaiians, particularly in the fields of health and education.

I will also take the opportunity to tell you a little bit about this unique, semiautonomous agency known as the Office of Hawaiian Affairs [OHA], and the role we play in the provision of services and for the betterment of conditions of native Hawaiians.

OHA was created in 1978 through an amendment to the constitution of the State of Hawaii, and subsequently was funded through the codification of ruling status by the legislature in 1979.

The Board of Trustees is comprised of nine members of Hawaiian ancestry elected by voters of Hawaiian ancestry in a special election funded and conducted in concurrence with the general elections of the State.

OHA is statutorily charged with serving as the principal public agency in Hawaii responsible for the performance, development, and coordination of programs and activities relating to native Hawaiians and Hawaiians, except those within the jurisdiction of the Hawaiian Homes Commission.

OHA is expected to conduct advocacy efforts, assess the policies and practices of other agencies impacting on native Hawaiians and Hawaiians, and apply for, receive, and disburse grants and donations from all sources for its beneficiaries.

We wish to assure you that the past support Congress has provided in the field of education is already assisting Hawaiians to improve themselves through a wide variety of educational programs and opportunities. Employment choices have expanded, and attitudes are changing so that Hawaiian children now dare to aspire to a better life.

OHA's role has been to work cooperatively with private and governmental educational institutions, providing special programs and projects, community outreach, monitoring and generally supporting and filling in the gaps without duplicating services.

We provide information and referral services through a community network that includes five offices on the neighbor islands. We have worked with all levels of education, kindergarten to higher education, and we strongly support the efforts of our colleagues at Kamehameha Schools as they strive to maximize educational opportunities for native Hawaiians.

OHA is an active participant and advocate in the organization known as Papa Ola Lokahi, explained in testimony presented earlier today. And we agree completely that the Native Hawaiian Health Care Act of 1988, Public Law 100-579, is desperately needed to improve and maintain the health status of our beneficiaries.

While Hawaiians are gaining in some respects, we suffer from dismal health problems that statistics clearly verify. To this end, we are pleased to report that the legislature of Hawaii has just allocated moneys to OHA and the Office of Hawaiian Health, State department of health, that are earmarked as matching funds for Papa Ola Lokahi.

We are grateful for your congressional support in authorizing funds and urge the confirmation of your continued support to full funding of these programs.

The Office of Hawaiian Affairs is committed to make these programs operational: One, by cooperating and coordinating with the other organizations of Papa Ola Lokahi; two, by continuing our affiliation and joint projects with Kamehameha Schools; three, through the provision of in-kind assistance of staff and facilities; and four, through an unwavering commitment to better the health conditions and educational levels of our beneficiaries.

PREPARED STATEMENT

Thank you for the opportunity to testify, and tell you about ourselves while we ask for your continued help.

Senator INOUYE. Thank you very much, Tommy.

[The statement follows:]

STATEMENT OF THOMAS KAULUKUKUI

ALOHA CHAIRMAN HARKIN AND MEMBERS OF THE COMMITTEE. THANK YOU FOR THE OPPORTUNITY OF TESTIFYING BEFORE YOU TODAY, AND THANK YOU TOO FOR YOUR CONTINUING SUPPORT OF PROGRAMS TO NATIVE HAWAIIANS, PARTICULARLY IN THE FIELDS OF HEALTH AND EDUCATION.

I WILL ALSO TAKE THE OPPORTUNITY TO TELL YOU A LITTLE BIT ABOUT THIS UNIQUE, SEMI-AUTONOMOUS AGENCY KNOWN AS THE OFFICE OF HAWAIIAN AFFAIRS (OHA), AND THE ROLE WE PLAY IN THE PROVISION OF SERVICES AND FOR THE BETTERMENT OF CONDITIONS OF NATIVE HAWAIIANS.

OHA WAS CREATED IN 1978 THROUGH AN AMENDMENT TO THE CONSTITUTION OF THE STATE OF HAWAII, AND SUBSEQUENTLY FUNDED THROUGH THE CODIFICATION OF RULING STATUTES BY THE LEGISLATURE IN 1979. THE BOARD OF TRUSTEES IS COMPRISED OF NINE MEMBERS OF HAWAIIAN ANCESTRY, ELECTED BY VOTERS OF HAWAIIAN ANCESTRY IN A SPECIAL ELECTION FUNDED AND CONDUCTED IN CONCURRENCE WITH THE GENERAL ELECTIONS OF THE STATE.

OHA IS STATUTORILY CHARGED WITH SERVING AS THE PRINCIPAL PUBLIC AGENCY IN HAWAII RESPONSIBLE FOR THE PERFORMANCE, DEVELOPMENT, AND COORDINATION OF PROGRAMS AND ACTIVITIES RELATING TO NATIVE HAWAIIANS AND HAWAIIANS, EXCEPT THOSE WITHIN THE JURISDICTION OF THE HAWAIIAN HOMES COMMISSION.

OHA IS EXPECTED TO CONDUCT ADVOCACY EFFORTS, ASSESS THE POLICIES AND PRACTICES OF OTHER AGENCIES IMPACTING ON NATIVE HAWAIIANS AND HAWAIIANS, AND APPLY FOR, RECEIVE AND DISBURSE GRANTS AND DONATIONS FROM ALL SOURCES FOR ITS BENEFICIARIES.

WE WISH TO ASSURE YOU THAT THE PAST SUPPORT CONGRESS HAS PROVIDED IN THE FIELD OF EDUCATION IS ALREADY ASSISTING HAWAIIANS TO IMPROVE THEMSELVES THROUGH A WIDE VARIETY OF EDUCATIONAL PROGRAMS AND OPPORTUNITIES. EMPLOYMENT CHOICES HAVE EXPANDED AND ATTITUDES ARE CHANGING SO THAT HAWAIIAN CHILDREN NOW DARE TO ASPIRE TO A BETTER LIFE.

OHA'S ROLE HAS BEEN TO WORK COOPERATIVELY WITH PRIVATE AND GOVERNMENTAL EDUCATIONAL INSTITUTIONS, PROVIDING SPECIAL PROGRAMS AND PROJECTS, COMMUNITY OUTREACH, MONITORING AND GENERALLY SUPPORTING AND FILLING IN THE GAPS WITHOUT DUPLICATING SERVICES. WE PROVIDE INFORMATION AND REFERRAL SERVICES THROUGH A COMMUNITY NETWORK THAT INCLUDES FIVE OFFICES ON THE NEIGHBOR ISLANDS. WE HAVE WORKED WITH ALL LEVELS OF EDUCATION - KINDERGARTEN TO HIGHER EDUCATION - AND

WE STRONGLY SUPPORT THE EFFORTS OF OUR COLLEAGUES AT KAMEHAMEHA SCHOOLS AS THEY STRIVE TO MAXIMIZE EDUCATIONAL OPPORTUNITIES FOR NATIVE HAWAIIANS.

OHA IS AN ACTIVE PARTICIPANT AND ADVOCATE IN THE ORGANIZATION KNOWN AS PAPA OLA LOKAHI, EXPLAINED IN A TESTIMONY PRESENTED EARLIER TODAY. AND WE AGREE COMPLETELY THAT THE NATIVE HAWAIIAN HEALTH CARE ACT OF 1988, PUBLIC LAW 100-579, IS DESPERATELY NEEDED TO IMPROVE AND MAINTAIN THE HEALTH STATUS OF OUR BENEFICIARIES. WHILE HAWAIIANS ARE GAINING IN SOME RESPECTS, WE SUFFER FROM DISMAL HEALTH PROBLEMS THAT STATISTICS CLEARLY VERIFY. TO THIS END, WE ARE PLEASED TO REPORT THAT THE LEGISLATURE OF HAWAII HAS JUST ALLOCATED MONIES TO OHA AND THE OFFICE OF HAWAIIAN HEALTH (STATE DEPARTMENT OF HEALTH) THAT ARE EARMARKED AS MATCHING FUNDS FOR PAPA OLA LOKAHI.

WE ARE VERY GRATEFUL FOR YOUR CONGRESSIONAL SUPPORT IN AUTHORIZING FUNDS, AND URGE THE CONFIRMATION OF YOUR CONTINUED SUPPORT THROUGH FULL FUNDING OF THESE PROGRAMS. THE OFFICE OF HAWAIIAN AFFAIRS IS COMMITTED TO MAKE THESE PROGRAMS OPERATIONAL: (1) BY COOPERATING AND COORDINATING WITH THE OTHER ORGANIZATIONS OF PAPA OLA LOKAHI; (2) BY CONTINUING OUR AFFILIATION AND JOINT PROJECTS WITH KAMEHAMEHA SCHOOLS; (3) THROUGH THE PROVISION OF IN-KIND ASSISTANCE OF OHA STAFF AND FACILITIES, AND (4) THROUGH AN UNWAVERING COMMITMENT TO BETTER THE HEALTH CONDITIONS AND EDUCATIONAL LEVELS OF OUR BENEFICIARIES.

THANK YOU FOR THE OPPORTUNITY TO TESTIFY AND TELL YOU ABOUT OURSELVES WHILE WE ASK FOR YOUR CONTINUED HELP.

STATEMENT OF KANANI MARIANO

Senator INOUYE. Our next witness is the principal leader of E Ola Mau, a major native Hawaiian health organization that has in recent years played a major role in elevating and improving the health conditions of native Hawaiians.

It gives me great pleasure to call upon Kanani Mariano.

Kanani.

Ms. MARIANO. Thank you.

Good morning, Senator Inouye, and Congressman Akaka, and members of the Senate Subcommittee on Health Care Appropriations.

My name is Kanani Mariano, a native Hawaiian. I am the executive director of E Ola Mau, a volunteer organization comprised of health professionals ranging from physicians to community-based paraprofessionals, all of whom are native Hawaiians.

I am here today as the vice president of Papa Ola Lokahi, the native Hawaiian Board of Health, as established by the Native Hawaiian Health Care Act of 1988.

Other members of Papa Ola Lokahi include the Office of Hawaiian Affairs, the agency established in the constitution of the State of Hawaii to assure the well-being and interests of native Hawaiians; the University of Hawaii, which has become the institutional leader in affirmative action programs that train native Hawaiian physicians, and which is involved in cross-cultural and clinical training and research, and sets the quality and standards of health care in the Hawaii medical community; Alu Like Inc., a federally funded native Hawaiian agency that promotes vocational training and the founding of community based organizations that promote health, education, and economic development for native Hawaiians; and the Office of Hawaiian Health in our State department of health, whose purpose is to ensure that native Hawaiians, along with their cultural beliefs and concepts, be respected, accepted, and worked within practice with the State department of health.

My purpose here today is to ask you to recommend full appropriations of the entire amount authorized by the Native Hawaiian Health Care Act of 1988. Your recognition of the alarming health status of our people led to the writing and subsequent passage of the Native Hawaiian Health Care Act.

For this, we thank you, and acknowledge that your demonstrated commitment to helping restore lokahi, a healthy harmony of self with others and all of nature, to our people.

For some, the word Hawaii conjures up visions of balmy weather, crystal blue waters breaking on white sand beaches, lush tropical valleys populated by happy, carefree, robust, healthy natives offering scented leis of aloha.

Gentlemen, the reality is that the indigenous people of Hawaii, the very source of aloha, are an endangered people.

In 1778, prior to contact with Western society, our population numbered in excess of 300,000. At a time when the United States was pursuing its goals of manifest destiny, over 90 percent of our people were wiped out by the infectious diseases brought by Western and Eastern contact.

By the year 1900, less than 28,000 native Hawaiians remained.

Today, Hawaii's population numbers 1.2 million, of which approximately 200,000 or about 17 to 19 percent are native Hawaiians.

Our people continue to die from diseases which are both preventable and treatable at a rate 34 percent higher than others in this Nation. The leading causes of death in the United States are chronic disease, heart disease, cancer, cerebrovascular disease, and diabetes mellitus.

The same is true for native Hawaiians, but we die at substantially higher rates than others in this Nation. Compared to the Nation's population as a whole, our age-adjusted death rates are 44 percent higher for heart disease, 39 percent higher for cancer, 31 percent higher for cerebrovascular disease, and an alarming 222 percent higher rate of death for diabetes mellitus.

To solve these problems, we need a health promotion and disease prevention program which will adequately address our native Hawaiian health needs.

Since the passage of the Native Hawaiian Health Care Act of 1988, Papa Ola Lokahi has taken immediate action to file incorporation papers. The native Hawaiian Board of Health has met regularly and is presently strategically planning to submit a detailed proposal at the appropriate time, requesting full appropriations of authorized funds.

The urgency of our people's situation demands immediate attention. The name of our native Hawaiian Board of Health, Papa Ola Lokahi, is a Hawaiian title that means the following: Papa means our foundation, our Earth Mother Goddess.

Ola means life, and Lokahi, the Hawaiian definition of health achieved by the working harmony of all involved.

Thus, Papa Ola Lokahi means a board founded on the principles and beliefs of our Mother Goddess, who nurtures the harmony and balance of life.

PREPARED STATEMENT

The members of Papa Ola Lokahi are committed to restoring and maintaining the health of our people. We ask for your support in this great task.

On behalf of Papa Ola Lokahi, mahalo—thank you—for the opportunity to testify.

[The statement follows:]

STATEMENT OF E. KANANI MARIANO

Good morning, Chairman Harkin, Senator Inouye and members of this Senate subcommittee on health care appropriations.

My name is Kanani Mariano, a Native Hawaiian. I am the executive director of E Ola Mau, Inc., a volunteer organization comprised of health professionals ranging from physicians to community-based para-professionals, all of whom are Native Hawaiian. I am here today as the vice-president of Papa Ola Lōkahi, the Native Hawaiian board of health, as established by the Native Hawaiian Health Care Act of 1988. Other members of Papa Ola Lōkahi include the Office of Hawaiian Affairs, the agency established in the Constitution of the State of Hawai'i to assure the well-being and interests of Native Hawaiians; the University of Hawai'i, which has become the institutional leader in affirmative action programs that train Native Hawaiian physicians, is involved in cross-cultural and clinical training and research, and sets the quality and standards of health care in the Hawai'i medical community; Alu Like, Inc., a federally-funded Native Hawaiian agency that promotes vocational training and the founding of community-based organizations that promote health, education and economic development for Native Hawaiians; and the Office of Hawaiian Health in our State Department of Health whose purpose is to ensure that Native Hawaiians, along with their cultural beliefs and concepts be respected, accepted and worked within practice with the State Department of Health.

My purpose is to ask you to recommend full appropriations of the entire amount authorized by the Native Hawaiian Health Care Act of 1988.

Your recognition of the alarming health status of our people led to the writing and subsequent passage of the Native Hawaiian Health Care Act. For this we thank you and acknowledge your demonstrated commitment to helping restore lōkahi, a healthful harmony of self with others and all of nature, to our people.

For some of you, the word Hawai'i conjures up visions of balmy weather, crystal blue waters breaking on white sand beaches, lush tropical valleys populated by happy, carefree, robust, healthy natives offering scented leis of aloha.

Gentlemen, the reality is that the indigenous peoples of Hawai'i, the very source of aloha, are an endangered people.

In 1778, prior to contact with Western society, our population numbered in excess of 300,000. At a time when the United States was pursuing its goal of Manifest Destiny, over 90% of our people were wiped out by the infectious diseases brought by Western and Eastern contacts. By the year 1900, less than 28,000 Native Hawaiians remained.

Today, Hawai'i's population numbers 1.2 million of which approximately 200,000, or about 17% - 19% are Native Hawaiian. Our people continue to die from diseases which are both preventable and treatable, at a rate of 34% higher than others in this nation.

The leading causes of death in the United States are chronic diseases: heart disease, cancer, cerebrovascular disease, and diabetes mellitis. The same is true for Native Hawaiians, but we die at substantially higher rates than others in this nation. Compared to the nation's population as a whole, our age-adjusted death rates are:

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To solve these problems, we need a health promotion and disease prevention program which will adequately address our Native Hawaiian health needs.

Since the passage of the Native Hawaiian Health Care Act of 1988, Papa Ola Lōkahi has taken immediate action to file incorporation papers. The Native Hawaiian board of health has met regularly and is presently strategically planning to submit a detailed proposal at the appropriate time, requesting full appropriations of authorized funds.

The urgency of our people's situation demands immediate attention.

The name of our Native Hawaiian Board of Health, Papa Ola Lōkahi, is a Hawaiian title that means the following:

Papa -	means our foundation, our earth Mother Goddess
Ola -	means life
Lōkahi -	the Hawaiian definition of health achieved by the working harmony of all involved.

Thus, Papa Ola Lōkahi means a board founded on the principles and beliefs of our Mother Goddess who nurtures the harmony and balance of life.

The members of Papa Ola Lōkahi are committed to restoring and maintaining the health of our people. We ask for your support in this great task.

On behalf of Papa Ola Lōkahi, mahalo (thank you) for the opportunity to testify.

Senator INOUYE. I thank you very much.

Most Americans are not aware that native Hawaiians are native Americans—they are the indigenous people of Hawaii, and the Congress of the United States recognized this in the early twenties, when our Prince Kuyiel Kolanayanioli, who was then a member of Congress, introduced a measure called the Hawaiian Homestead Act.

With the adoption of this act, and the enactment of this by the signing of the President, the United States recognized the special status of Polynesian Hawaiians. We set aside large tracts of land for that purpose, and for all these years, it has been upheld in the courts and all these years recognized by the Congress.

As such, as we do have with the native American Indians, there is the existence of a trust responsibility between the Government of the United States and native Hawaiians.

In the past, I believe that we made an error in dealing with native American Indians, because most of the solutions for Indian problems were made here in Washington with very little contact on reservations and with tribes and nations.

As such, history shows that Washington-made solutions have very seldom worked. That is the major reason for the passage of this bill calling upon Hawaiians to provide us with the solutions for their problems, and your presence here attests to this.

It is a very important step in carrying out this trust responsibility, so I for one am very pleased with the work that has been carried out by all of you, and I can assure you that the community of Indian nations and tribes are watching the progress of your organizations and they are very keenly interested in the progress being made.

I wish to commend all of you.

I have just a few questions.

A few years ago, when we had an examination of 5 year old native Hawaiian children, we found that over 40 percent had measurable hearing loss—an astounding number, so astounding that Gallaudet has now set up a special operation in the State of Hawaii.

Has this situation improved?

Mr. THOMPSON. Senator, we have just begun to work on that program, beginning May 1 of this year, with Gallaudet and the University of Hawaii, in conjunction with the Kamehameha Schools.

We are right now interviewing staff for that project, and we should be getting going and should be able to come back with some information next year.

Senator **Inouye**. I for one would be very interested, because it is inconceivable that 40 percent of a population be either on the verge of deafness or deaf. We have checked other ethnic groups, and there is no similar condition. Why just the Hawaiians?

I think there is a special role that we should be playing here, that I can assure you.

Mr. **Thompson**. Thank you.

Senator **Inouye**. How are the child maternal centers working out?

Mr. **Thompson**. They are working quite well. As Peter can attest to—he was out there—the traveling preschool, demand for that preschool is horrendous. We cannot keep up with it.

However, we are enthused about the participation, not only of the community, but the parents and the grandparents and the caretakers.

That particular model seems to be quite successful.

Senator **Inouye**. We do not expect to see great results in just a few years, but are you saying to us that the demand is now growing?

Mr. **Thompson**. Yes; it is.

This is why our request for next year is up to the authorized amount.

Right now, our institution for next year will be funding this program at the rate of $1.7 million, and the request to the Federal Government will be at the same level—$1.7 million.

For next year, we are requesting $2.4 million, and our costs will increase correspondingly.

Senator **Inouye**. For a long time, the Government of the United States had great difficulty even mentioning native doctors or medicine men, and therefore did not recognize their value.

I am pleased that in your organization, native doctors are included.

Mr. **Thompson**. Yes; it is.

Senator **Inouye**. After all, today, when you look at all these fancy medicines, you will notice that they include the ingredients that native Hawaiian doctors and native American Indian doctors have been employing for all these centuries.

One of the big moneymakers as used by most women—aloe.

Mr. **Thompson**. Yes; we lost that one. But——

Senator **Inouye**. Aloe is from Hawaii. You Hawaiians could have been multimillionaires by now.

Mr. Akaka.

Mr. **Akaka**. Thank you very much, Mr. Chairman.

I want to welcome all of you here to Washington, DC, and thank you for bringing the good weather we have been enjoying these past few days.

I want to congratulate and commend you folks, Pinkey, Meyer, and Thompson, for your work up here. You have been one of the pioneers that have really helped push these programs with the Senator as leader, and these programs have come to fruition.

I would grant that I had a small part in trying to bring this about, so we need to thank you very much, Pinkey, for your efforts and you continue to search out the needs, the dire needs, of our Hawaiian people. You have been very instrumental in conveying your ideas that can be put into legislation.

I also want to thank Uncle Tommy Kaulukukui, for his work as president of OHA, of the trustees of OHA. The work you are doing there, we know that the Office of Hawaiian Affairs is dedicated toward the betterment of Hawaiians, which leaves it wide open.

I look upon you as an institution that can do maybe what others cannot do legally. But we have so much work to do to better the conditions of the Hawaiians.

Kanani Mariano, I want to thank you for your thoughts along the line of health for the Hawaiians, and I am glad to see that the native Hawaiians are fulfilling this area, and that is to help heal people who are healed in Hawaii.

All of the rest of you, who have come, too, I want to thank you for coming. We have a huge responsibility.

The Senator mentioned that we use the word trust, that we have a trust relationship or trust responsibility, which is a very important word that justifies what we are trying to do for the Hawaiians.

We will continue to look to you as the Senator mentioned earlier for your thoughts in how to continue to help the Hawaiians.

I want to say that since you have come along, all of you, that Hawaii is really turning the corner toward a new kind of future, and a future that requires the support and assistance of the Federal Government. We hope that we can continue to work together to bring about better results.

Thank you very much, Mr. Chairman.

Senator **Inouye**. Thanks to all of you for having traveled this long distance to be with us. Would you care to say something? Here is your opportunity.

Ms. **Franklin**. Senator, I want to thank you very much on behalf of all Hawaiians. Thank you very much.

Senator **Inouye**. Thank you.

Well, if not, once again, thank you very much, and we look forward to continue working with you, and I can assure you that we will do our best to provide the funds that are necessary.

Mr. **Thompson**. Senator, may I make just one comment, only because I have the microphone.

I am taking this liberty to represent all of us to say thank you to Congressman Akaka, yourself, the rest of our delegation, for the support that you have given us in getting these programs going.

Congressman Akaka, yes; the responsibility is great, and the ball is in our court. Congress has acted, and we are ready to go.

Thank you.

Senator **Inouye**. Thank you.

Mr. **Akaka**. Mr. Chairman?

Senator **Inouye**. Yes.

Mr. **Akaka**. May I continue to say Dr. Satoru Izutsu is a very close friend of mine. We did some other things before he even became a doctor, while at the university.

I want to welcome you, and all the efforts you have had in health.

Also, Sheryl Franklin and Bob Springer of Kamehameha Schools, for your efforts with education in Hawaii, and, of course, Havnani Apoliano is not only noted as someone from heading Alu Like, but she is noted as a musician, and a cultural expert in Hawaii. It is so good to have you here.

Richard Paglinawan, newly appointed executive person of Office of Hawaiian Affairs. I want to wish you well in your new responsibilities.

And, also, Brian Martin. It is good to have all of you here, and I want to say aloha and best wishes.

PREPARED STATEMENT OF U.S. REPRESENTATIVE PATRICIA SAIKI

Senator **Inouye**. Thank you.

Before we proceed, I have been requested by my illustrious colleague from the House, Representative Patricia Saiki, that she be permitted to submit a statement. Without objection, Congresswoman Saiki's statement will appear at this point in the record.

[The statement follows:]

Statement of Congresswoman Patricia Saiki

Mr. Chairman, I believe that the health and educational needs of native Hawaiians have been overlooked for far too long. I applaud the efforts of Senator Inouye in this area and I wholeheartedly support full appropriations for native Hawaiian programs.

I find it disturbing that Hawaii residents have the longest life expectancy in America, but that native Hawaiians suffer from notoriously poor health and a remarkably high rate of mortality. The unique health problems of native Hawaiians have not been adequately met by traditional government health programs. For this reason, funding for community-based native Hawaiian health care authorized under PL 100-579 is so critically important.

There also appears to be a correlation between economic standing and health in most populations and I feel education is the best cure for poverty. With strong native Hawaiian education programs I am confident that this downward trend in the quality of health and economic status can be broken altogether. Unfortunately, the Administration did not include funding under the Hawkins-Stafford Amendments for Native Hawaiian education. I strongly urge the Members of this Committee to include funding for Native Hawaiian Education in its fiscal year 1990 appropriations bill.

Assistance in the form of health care and education is desperately needed. Congress has already agreed to support Hawaiian health and education programs in the Native Hawaiian Health Care Act of 1988 and the Hawkins-Stafford Elementary and Secondary School Amendments. These authorizations deserve full funding.

I thank the Chairman and the Members of the Subcommittee for addressing this issue which is so critical to my home state. I appreciate this opportunity to lend my support and I urge my Senate colleagues to approve full appropriations for Hawaiian health and education programs.

STATEMENT OF DR. MARVIN ANDERSON, PRESIDENT, HAWAII LOA COLLEGE, OAHU, HI

Senator **Inouye**. Our next witness is the president of the Hawaii Loa College on the Island of Oahu in the State of Hawaii, Dr. Marvin Anderson.

Dr. **Anderson**. Thank you very much, Senator Inouye.

I want to express my appreciation to you, in particular, for all you have done, not only for the State of Hawaii, but for Hawaii Loa College.

We trust that we can justify your confidence in us.

I am going to make this very brief. My formal report has already been submitted. But I would like to touch on two things.

One is the college itself. The name Hawaii Loa College was named after the legendary Polynesian explorer who discovered Hawaii. I think that name reflects what the college is all about.

It is a liberal arts college with a very, very strong international Pacific focus. As was stated very recently by the Western Association of Schools and Colleges accreditation commission, they found that Hawaii Loa College was far ahead of most colleges on the Mainland with reference to integration of a multicultural society.

We have students coming from 14 different islands and Asian rimland nations. We have 52 percent of our students from Hawaii. Many are Hawaiians. We have a number of Samoans, and so on.

What the college is attempting to do, in terms of education, is to provide an educational opportunity for the entire spectrum of ethnic groups in the State and throughout the Pacific area and the Asian and Pacific rimland nations.

Of course, as an independent private residential liberal arts college with that strong Pacific focus, the need for scholarships is extremely great. Fortunately, we have a number of scholarships that have been provided by the sponsors of the college—originally the four mainline denominations, the Methodist Church, the Episcopal, the Presbyterian, and the United Church of Christ.

That has enabled us to develop a substantial number of scholarships, not only in Hawaii, but throughout the Pacific Basin.

The question is, what can we as a college do as a good neighbor, and as a partner in the educational enterprise in the State of Hawaii? I think that the college has attained the reputation as a good educational institution, and we are now in the process of developing what we call the Pacific Village Network or cluster, which is a—you might call it—concretization of the rhetoric that we have stated so often.

That is a community of students and scholars on the college campus that come from different parts of the Pacific area, the Pacific islands, the Asian rimland nations, as well as the United States, the Mainland here and Canada, and so on.

The second part is, what can we do in terms of service to the community? One of our strong programs is our nursing program. We have a 2-year program, a 3-year, and a 4-year program, with a substantial number of our students coming from the community and different ethnic groups. We also provide special programs for students that have not had the opportunity to attend a nursing program before.

Second, we have what we call the special programs dealing with degree completion and so on, that are now available to many of the so-called minorities.

The problem in Hawaii is that there are no minorities—we are all minorities, and I think the Hawaiian spirit exemplifies that particular fact, and that the Hawaiian spirit has been the adhesive of our society.

We have done a considerable amount of work in the area of research dealing with the mental health problems particularly of the native Hawaiians, and we have discovered that we have, in many respects, regressed.

Under the monarchy, the treatment of mental health people was frankly much superior to that we are giving them today, or had given them, and they had a philosophy of what we call informal community care and institutional treatment, with patients sliding back and forth.

In other words, there was family involvement, and there was community involvement, and subsequent to that, after the termination of the monarchy in 1893, and the overthrow of the monarchy, under a new regime, we developed what we call a very regimented, very isolated type of handling of the mentally ill.

The result was disastrous. We are now beginning to recognize, as this country is recognizing, that more and more that community involvement, family involvement, is a very important part of health care.

So, we have now progressed in terms of our own research, up to 1900. We are now proposing to continue our research activities in that area from 1900 to 1989.

That deals with the exploration and documentation of the organization and delivery of care of the mentally ill in Hawaii from that period. Also, the exploration and documentation of the social conditions underlying the evolution and functioning of the mental health systems in Hawaii from 1900 to 1989, examination and documentation of mental health laws which have a tremendous impact on the mental health system in Hawaii from 1900 to 1989.

In other words, we are trying to lay the foundation and the basis for developing a truly sensitive and effective mental health program, and as a private, independent college deeply committed to Hawaii, and as you, sir, we offer our services in any respect that we can do so.

PREPARED STATEMENT

Thank you very much, Senator, for all you have done for us, and thank you for listening to me. It has been an honor and a pleasure to travel these miles to attend this session.

[The statement follows:]

STATEMENT OF DR. MARVIN ANDERSON

One of the most intractable problems presented to a democratic and compassionate society is the care of those citizens whose mental state leads them to disruptive behavior which endangers the majority and the peaceful conduct of affairs.

Today we can recognize various degrees of mental illness ranging from what might regarded as "excessive" eccentricity to a truly mindless violence for which the only solution seems to be incarceration. Similarly we are able to distinguish among those kinds of mental illness due to "organic" brain damage, typically consequent to injury, syphilis or advanced alcoholism, and those in which the lesions, if any, are of a subtler biochemical nature.

Our testimony concerns that great mainstream of the mentally ill who suffer from schizophrenia of various degrees of severity and those with bi-polar diseases, also known as manic depressives, and encompassing those broadly classified in earlier times as melancholics.

Well into the eighteenth century, "lunatics" were kept chained and caged, and often put on display for paying customers to view and torment. With the Age of Reason, Pinel and Tuke in France laid the foundations of compassionate "asylums", and it is noteworthy that the gentle connotation of "asylum", as a refuge for the lost, scared and bewildered has been lost in the subsequent grim history. The great contribution of these pioneers was to recognize that those who had lost their reason were not sinful nor did they merit punishment. This was a tremendous conceptual step, but part of the treatment they developed was the confrontation of the "madman" with his "madness", and this was achieved with an iron discipline, although not one involving corporal punishment. At the same time, by extension of the medical theories of the time, it was considered that icy cold hoses did relax the nervous system and make the inmates more likely to face up to the delusionary nature of their delusions, for example.

The Quakers too, had a predictably civilized approach.

"The worthy Society of Friends.....sought to assure those of its members who might have the misfortune to lose their reason without sufficient fortune......a voluntary subscription furnished the funds.........If the soul momentarily quails at the sight of that dread disease which seems created to humiliate human reason, it subsequently experiences gentler emotions when it considers all that an ingenious benevolence has been able to invent for its care and cure".

Unfortunately, the leadership in these non-punitive approaches to mental illness was conceptually far ahead of the attendants and physicians who had the day-by-day care of the inmates, and this was exacerbated by the timeless problems of budget, insufficient and poorly trained personnel. The brutal fact was that incarceration and the punitive use of "therapeutic" discipline made it easier to manage the growing number of asylum inmates. The soul does indeed quail at the horror of the lives of men and women shut up for life in those vast structures, with no segregation of patients by symptoms, run by a soul-less bureaucracy and staffed (with some saint-like exceptions) with brutal and brutalized attendants.

Hawaii: a special case ?

Preliminary studies suggest that previous to western contact and for some time thereafter, Hawaiian communities were tolerant of mental illness which did not lead to murder or rapine, and families took care of the afflicted as they would any other sick (or retarded) relative. One could expect that this "open" supervision did not threaten the patient as much as confinement and led to less violent expressions of the underlying illness.

The Hawaiian Monarchy in the latter part of the Nineteenth Century were understandably impressed with the advanced nature of the western powers and perhaps, because of the monarchial tradition, they were particularly taken with the Court of Queen Victoria and British institutions.

In the present context then, it followed that an asylum was constructed and staffed in Hawaii, but our early studies show that its administration combined the "orderliness" of a custodial institution with the open-ness of the traditional family care of the mentally ill. This may have been in consequence of the Hawaiian Monarchy's assumption of a European-type *noblesse oblige*, but it remains likely that the traditional family system continued to permeate the operation of the asylum so long as the Executive was itself Hawaiian in culture. We have found that there was not a rigid separation of custodians and patients, and family members came and went with great facility.

With the overthrow of the Hawaiian Monarchy in 1883 and the subsequent annexation of the Hawaiian Islands to the United States, this open custodianship gave way to a particularly repressive prison-like asylum under the direction of an American named Herbert.

Curiously, despite this repressive system and the inevitable standardization of asylums as the Federal Government became involved in the funding and accreeditation thereof, elements of the "family" style of care persisted well into the 1970s. Kindly Hawaiian attendants treated docile patients as erring members of the extended family and frequently took them to their own homes on week-end passes.

As is well known, the availablity and use of Thorazine and similar anti-psychotic drugs accelerated an already noted, but unexplained, decline in the number of in-patients in mental hospitals. In Hawaii the census fell from 2000 in 1959 to 600 in 1969. This fell below 200 by 1972, but this further decline is regarded as a consequence of the shifting of Federal funding away from in-patient facilities to Defined Community Mental Health Centers. Because of the difficulties of treating some patients on an out-patient basis, the census quickly rebounded to about 250. One view is that the second drastic reduction in the numbers of inpatients placed those patients in a loose and unfocussed hospital made up of the Mental Health Centers instead of the coherent and generally benign State Hospital, which was by this time (perhaps on account of Thorazine) fairly manageable in terms of patient population.

A difficulty faced by all developed countries is that "discharged" mental patients remain stable only so long as they take their medications. A small number are able to reurn to stable and loving homes in which the maintenance of the therapy can be attended to, but many such patients are alone and consequently "non-compliant" with respect to their medication, and this is exacerbated as their disorientation worsens in consequence of not taking the stabilizing medication. This is not to suggest by any means that the homeless people of the great western cities are all neglected mental patients, but they do form a significant fraction thereof.

A report published by Dr. Fuller-Torre of Mr Ralph Nader's organization later rated Hawaii's mental health system the worst of all fifty states. The major criticims were leveled at the absence of a properly accredited State Hospital and a failure to coordinate properly inpatient and outpatient treatment. The initiative of then-Governor Ariyoshi obtained funds for the new hospital which is under construction.

Proposal. At Hawaii Loa College we will continue our studies of the history of the care of the mentally ill in Hawaii with particular reference to the possibility that the traditional culture's pattern of the benign care of such patients is alive and well, and may form a model for Hawaii (and other places) to develop patterns of care consistent with reality, compassion and a decent Respect to the Opinions of Mankind.

Senator **Inouye**. Dr. Anderson, so that there will be no misunderstanding, I think the record should show that I am honored to serve on your Board of Trustees. So, if I am very supportive of your organization, it is not necessarily because of my service on the board, but because I believe in your innovative programs, your desire to have an integrated school that would use the talents and the skills of the people who reside around us in the Pacific Ocean.

I can assure you that I am very proud of my membership on your board.

Dr. **Anderson**. Thank you very, very much, sir.

Senator **Inouye**. You have done a job that many of us thought was not possible. I think the record should show that when Dr. Anderson took over the helm, that school was in dire straits, financially and otherwise.

Today, we are not only floating, but we are sailing forward, and that is under your leadership, sir.

Dr. **Anderson**. Thank you.

Senator **Inouye**. We thank you.

Dr. **Anderson**. Thank you very much.

Mr. **Akaka**. Thank you, Mr. Chairman.

I only want to add my congratulations to Dr. Anderson. You have sustained and led very well in higher education, and I congratulate you for what you are doing.

Dr. **Anderson**. Thank you very, very much, Congressman.

I might add just one comment. We have felt for a long time that liberal arts college has been considered mostly a college that portrays and teaches the cultures and the knowledge of the European and the Western cultures.

We believe that this college can be a truly liberal arts college, that brings in the cultures of the Asian and Pacific area and really enriches the whole educational process.

Thank you very much.

Mr. **Akaka**. Thank you, Mr. Chairman.

May I also add that I want to commend you on your search into the Hawaiian culture, for answers to some of the problems of the community.

You are correct, and I am happy that you mentioned, about the informal community care that the Hawaiians had. The families took care of their ill, and we can go all the way to what we call the hanai system, where people took the children, or families and friends took children and cared for them.

There are many other systems of care that the Hawaiians had, and I am glad that you are looking into that.

Dr. **Anderson**. Thank you very much.

Senator **Inouye**. I thank you, sir.

STATEMENT OF MARY LOU MUNTS, NATIONAL ASSOCIATION OF REGULATORY UTILITY COMMISSIONERS

Senator **Inouye**. I hope that the two remaining Hawaiian witnesses will not mind a slight break at this point.

I have been advised that Mary Lou Munts of the National Association of Regulatory Utility Commissioners is scheduled to testify before a committee in the House, and to accommodate her, if I may, I would like to call her up at this time.

Ms. Munts, welcome.

Ms. MUNTS. Senator, I am extraordinarily pleased to be here before your committee, and to interrupt your wonderful testimony from your residents of Hawaii. I think that for me, it has been a great pleasure to hear this much about your State.

I know that you came to our State and spoke recently, and people were enormously impressed with you, and I have had the chance to hear you today, and I know why your colleagues are as well. So this is for us a pleasure to be able to bring a very different note, because the Low Income Energy Assistance Program is of great interest to our State, and I think to most States where regulatory utility commissioners serve.

We are a national organization that was founded 100 years ago. We follow legislation on the Hill very closely. This particular program is one that, even though it may affect your State less, I know of your concern about social problems, and the kinds of things that affect us.

In our case, we have many native Americans who are among the recipients of low income energy assistance. It happens to be the largest income transfer program, I think, for our State and many others. It is too often thought of as a welfare program. It is not a welfare program, and given where energy costs are today, we think that it looks as if they will be going up again. We urge you very strongly not to follow the lead of the administration in cutting the program from $1.4 million to $1.1 million.

Back in 1985, we were at $2.1 million, and from our standpoint, this cut of one-third that we have taken means that I think the low income energy assistance program has taken its full share. To cut it down to what would be only one-half would be a tragic mistake for the many poor who are able to use this to make energy bills stretch and not have to do the kinds of desperate things that we have seen people in our State do—to turn to inadequate kinds of heating appliances and to really risk death rather than face cold.

So, this is something that I hope you will give leadership to, along with your colleagues. I would particularly call to your attention some of the arguments on oil overcharge that we feel have been really a kind of phantom that has led people to think there is something else out there.

Most States have committed those funds. They were never intended to be a replacement—just a supplement, rather than a replacement.

There are not other resources to turn to, and the Federal Government, I think, has been a great leader in helping the poor who feel that energy is something that they cannot do without, and for obvious reasons.

Therefore, we find people will use this program, particularly the elderly and the near-poor who would not turn to other programs. Without it, and with supplementary programs not available, we would find ourselves, I think, in a situation where we find more overcrowding of families.

The kind of cycle we see in a big city like ours, Milwaukee, where people move to stay ahead of utility bills, this just does not make sense.

I have filed a written statement, and I just want to say on behalf of all of the regulatory utility commissioners of the country who passed a resolution at our last meeting, unanimously, urging that you try and have funds at at least the level of $1.6 million—it is currently $1.4 million.

PREPARED STATEMENT

At the very least, we hope that you would keep it at $1.4 million, with some hope that those funds can be increased, because the need is very great.

Thank you very much, Senator, and I hate to have interrupted your Hawaiians.

Senator **INOUYE**. Not at all, Madam.

Ms. **MUNTS**. They are a wonderful group, and you represent a wonderful State.

[The statement follows:]

STATEMENT OF MARY LOU MUNTS

My name is Mary Lou Munts. I am a Commissioner of the Public Service Commission of Wisconsin and Vice-Chair of the Committee on Energy Conservation of the National Association of Regulatory Utility Commissioners, or NARUC, on whose behalf I appear today.

The NARUC is a quasi-governmental, nonprofit organization founded in 1989. Within our membership are the governmental agencies of the 50 states, the District of Columbia, Puerto Rico, and the Virgin Islands, engaged in the regulation of utilities and carriers. We are charged with the protection of the public interest, and it is with this in mind that I appear before you today in support of restored funding for the Low Income Home Energy Assistance Program (LIHEAP).

NARUC deeply appreciates the opportunity to address this committee to express our strong support for this extremely important program that literally keeps millions of American families warm and safe. We recommend that the funding be restored to the FY 1988 level of services, or something approaching $1.6 billion. This position was unanimously adopted by the NARUC executive committee at its 1989 winter meeting in Washington, D.C. A copy of our resolution is attached hereto.

We believe that LIHEAP has already contributed more than its share to reducing the nation's deficit. LIHEAP at its peak in FY 1985 was funded at $2.1 billion, while last year it had been cut to approximately $1.4 billion. It is unconscionable to cut this program further; yet the Administration's budget would cut it by approximately $300 million.

While some may feel the energy crisis is over, members of this committee and all of Congress and the Bush Administration must realize that the energy crisis has never let go of its grip on millions of poor families throughout the United States. While typical middle class households, through wage increases and conservation expenditures, have reduced their annual bills to around 4 percent of their annual incomes, average poor families often face annual heating bills amounting to 13-16 percent of their annual incomes. Many recipients of LIHEAP benefits include the working poor, the elderly, and mentally or physically disabled people, who have been passed by during the "economic good times" of recent years. It is more true today than ever that many times they must choose between eating and heating.

If the proposed cut in LIHEAP is approved, the program funds will have been cut by nearly one-half since FY 1985. It would be a terrible and shameful act for this nation to shift an additional $300 million energy burden onto the backs of the poor when they cannot even pay their current energy bills. To make matters worse, energy prices in most locations throughout the nation are projected to rise, according to the U.S. Department of Energy. In the face of declining real incomes and rising energy prices, this is certainly not the time to cut the meager fuel assistance that poor families use to help pay a few energy bills and weatherize a few of their homes.

Both Congress and the Administration have been distracted by the phantom of oil overcharge dollars. In most instances, the overwhelming bulk of those dollars distributed to the states have either been spent or encumbered, and are no longer available. Moreover, those oil overcharge funds were designed to make up for past injuries and were to supplement, but not supplant, existing federal and state resources. Even if the oil overcharge dollars could somehow be used to replace lost federal dollars, there would not be enough to make up past cuts, much less for the proposed LIHEAP reductions.

It is imperative to note that LIHEAP has never been funded to assist more than 30 to 40 percent of the eligible households that need this program to maintain safe energy in their homes. If funding is not restored to an adequate level of at least $1.6 billion, many state programs will have to either cut hundreds of thousands of recipients or reduce benefits to an almost meaningless level. More than 600,00 households have already been eliminated from LIHEAP because of past cuts.

As state utility regulators, we continually face situations throughout the country where consumers unable to pay their bills are shut off. When hundreds of thousands of families with children and elderly go without heat, dangerous conditions arise as desperate people turn to electric space heaters, gas ovens or poorly constructed wood burning stoves to heat their homes. It is ironic that the poor in these situations can face either the risk of losing life to winter's bitter cold or the horrors of accidental fire caused by a dangerous supplementary heating device.

Private assistance is too small, too stretched, and too spread out to fill the growing gap left by shrinking federal LIHEAP assistance. Utility disconnection moratoriums give protection in some states. But, there are many more millions of families who have inadequate protection, because they use fuel oil, LP and other unregulated fuels.

We have heard about, but have not researched, a growing problem caused by high energy prices and low fuel assistance: a pattern of poor families moving several times a year to stay ahead of utility bills. These families, often with very young children, move too often for the youngsters to maintain an educational continuum in their schools. If a child from a disadvantaged home is pulled out of two or three schools in a year, it is easy to see that such a child is probably doomed to a terribly inadequate educational foundation and later doomed to repeating the poverty cycle.

For example, in the Milwaukee area, we know that more than 5,000 families have doubled or tripled up in homes because of their shrinking incomes and growing living expenses, particularly utility bills and rent. A further reduction in LIHEAP will only worsen this dangerous social situation in our low income homes.

Many states reviewed their fuel assistance programs in cooperation with their energy suppliers so that these programs can be more efficient and target the precious few dollars to those who need them most. For example, I have chaired several task forces and committees that led to reform of the Wisconsin LIHEAP program so that the greatest benefit will go to the poorest families with the greatest heating needs. Other states are carrying out similar reforms. The point that I am making here is that we are doing better with the few dollars that are still available, but further reductions will undermine these improvements.

It is wrong to think that LIHEAP benefits are simply another form of welfare for those people on other traditional public assistance programs. Approximately 65 percent receive no other traditional public assistance. Many of the LIHEAP recipients are the working poor.

NARUC implores this committee to insure that LIHEAP is funded at least at $1.6 billion. There must be room in the federal budget for adequate LIHEAP funding so the poor will at least have warmth in their property.

Thank you.

Resolution Urging Congress to Restore Critical Federal Funding for the Low Income Home Energy Assistance Program for FY 1990

WHEREAS, The National Association of Regulatory Utility Commissioners (NARUC) recognizes the critical role that the Low Income Home Energy Assistance Program (LIHEAP) has played in providing assistance to millions of households in meeting their energy needs; and

WHEREAS, The Executive Committee of the NARUC adopted a resolution urging Congress to increase the funding for LIHEAP and the Weatherization Assistance Program at its 1988 Winter Meeting in Washington, D.C.; and

WHEREAS, LIHEAP is a needs-based income supplement program serving only very needy households, of which more than 60 percent have annual income under $6,000; and

WHEREAS, More than one-half of the households that receive LIHEAP are the working poor or elderly, and 65 percent of LIHEAP families do not receive any other type of public assistance; and

WHEREAS, LIHEAP funds help to pay the heating and cooling bills of approximately 6.2 million households, provide emergency energy assistance to those in urgent life-threatening situations, and may be used for weatherization of low-income households; and

WHEREAS, The average LIHEAP-eligible household spends 14 percent of its income on energy, which is four times that paid by middle income households, and the real income of poor families has not risen as fast as inflation, thus causing a dramatic drop in their buying power; and

WHEREAS, The program has suffered a 35 percent cut over the past three years (from $2.01 billion in FY 1986 to $1.38 billion in FY 1989) despite the obvious need to increase energy payment assistance, and those cuts eliminated more than 600,000 poor families from the program while LIHEAP benefits were also reduced; and

WHEREAS, Utility commissions find that inadequate funding and recent cuts to LIHEAP have contributed to great hardship to elderly and low-income households, resulting in thousands of families having to double up and triple up in crowded homes and apartments; and

WHEREAS, In the Reagan FY 1990 budget proposal, the LIHEAP would be cut another $283 million, or 21 percent, which could eliminate more than 1 million more poor families from the program and the Bush budget may require even deeper cuts; and

WHEREAS, The U.S. Department of Energy is projecting that average residential prices for all primary heating fuels will rise in 1989; and

WHEREAS, Final State decisions have been made regarding most of the oil overcharge funds that the States have received and the amounts committed to LIHEAP are far too small to make up for past LIHEAP reductions, much less additional reductions, even if they legally could be used to supplement Federal and State resources; now, therefore, be it

RESOLVED, That the Executive Committee of the National Association of Regulatory Utility Commissioners, assembled at its 1989 Winter Meeting in Washington, D.C., reaffirms its support for LIHEAP; and be it further

RESOLVED, That the Executive Committee of the NARUC urges Congress to provide sufficient funds to restore funding to a level of $1.6 billion for FY 1990, equal to the FY 1988 level of services.

Sponsored by Committees on Administration and Energy Conservation
Adopted March 1, 1989

Senator **Inouye**. Not at all.

In fact, testimony such as yours is very essential, because we who have the privilege of serving in the Congress of the United States, who ride to work in well-heated cars or air-conditioned cars, who serve in buildings that are precisely acclimated to our needs, and go home to well heated or well air-conditioned homes, oftentimes lose sight of the misery and the plight of the very poor.

The fact that you have traveled long distances to tell us about that plight will help a lot. I can assure you that when the time comes, I will recall your testimony.

Ms. **Munts**. Thank you very much, on behalf of the commissioners, and my other commissioners in Wisconsin. We have taken a great deal of interest in this, and we appreciate very much the opportunity to testify.

Senator **Inouye**. Thank you very much.

STATEMENT OF DR. FRED GREENWOOD, DIRECTOR, PACIFIC BIOMEDICAL RESEARCH CENTER

Our next witness is Dr. Fred Greenwood, director of the Pacific Biomedical Research Center.

Dr. **Greenwood**. Mr. Chairman, Congressman Akaka, thank you very much for the opportunity to testify before your committee. It is my first opportunity.

I direct the Pacific Biomedical Research Center at the University of Hawaii, and for the past 15 years, I have coordinated four NIH programs, which address the needs for the training of minority health scientists.

They also address the issue of improving the infrastructure for research and the goal, of course, is to improve the health of minority populations.

These NIH programs offer hope for the future. I am also able today to speak for the Association of RCMI programs. The association brings together representatives from those institutions receiving an RCMI grant from NIH. This program is called the research centers in minority institutions, and it supports research infrastructure in 17 traditional and nontraditional minority schools.

These have many things in common, including the opportunity to train minorities for the Ph.D. degree. University of Hawaii is one of those institutions.

The testimony that we prepared and submitted was unanimously endorsed by the association at its meeting in Houston on April 22.

That meeting also, Mr. Chairman, recognized your sterling efforts on behalf of the minority research programs over these many years.

I would like to add my personal note—I think that without your help, I would have given up a long time ago.

We want to address three concerns. The first is the impact of demography on the training of minority health sciences in the 1990's.

The NIH and other DHSS programs addressing these needs must be maintained, and they may need to be expanded for a very simple reason, and that is by the year 2000, there will be 22 percent fewer 18-year-olds, and an increased proportion of the school-age population will be minority students.

They will be up to one-third of our graduating high school seniors. We must position ourselves to make increasing use of this human resource pool by increasing the number of students that we are reaching, by increasing the quality of the training offered to these undergraduate and graduate students.

Our second concern is the RCMI program itself, and the AIDS problem.

Now, the RCMI program was a significant development by NIH in improving the research infrastructure in minority institutions. It was only started in 1985, and the selection by NIH of those institutions offering research training for the Ph.D. degree was commendable. There have already been some major impacts.

I have not got the time, obviously, to detail them. But the success of the RCMI program in improving the research capability of these minority institutions becomes terribly relevant when we consider the AIDS problem itself, and its disproportionate effect on minority populations.

The RCMI institutions were challenged by the NIH office that runs that program to become involved in the AIDS problem, because, for example, blacks and Hispanics constitute some 18 or 20 percent of the U.S. population, but they make up 42 percent of the AIDS cases.

AIDS is HIV, and in Hawaii, we have an HIV and an HTLV program, as outlined in the written testimony.

Now, I am very pleased to say that the RCMI institutions responded to the challenge by developing position papers of how their institutions could develop research on the AIDS problem.

A meeting was convened in Honolulu in March of last year, in conjunction with the deans of the schools of public health from the Asia Pacific region—a very unique type of meeting.

The proceedings have been published, and essentially from that meeting, which was a public critique, five proposals were subsequently submitted to NIH for infrastructure support. All of those committed their institutions to matching efforts.

They survived the peer review process, and were recommended for funding.

The Association of RCMI programs are not awfully happy to report that not one program has yet received funding from the 1989 budget to meet these initiatives.

The future seems somewhat bleak, because the NIH appropriation requested for fiscal year 1990 gives only a 3.4-percent increase over the 1989 budget.

The RCMI program needs not just the $15.8 million in the President's request, but an additional $6 million to fund these AIDS and other initiatives.

Now, our final concern is more general. In a sense, it is the future of minority research training programs at NIH, and their funding. The RCMI institutions were really pleased to welcome the move at NIH to develop a corporate plan for the first time, to develop a corporate plan setting out specific objectives for the support and training of minorities for research.

This is really welcome, because I have not had time to detail the alphabet soup that we deal with—MBRS, MARK, MHSP, RCMI programs.

Now, it is timely for them to develop a corporate plan, and the association feels that the corporate plan should also implement a recommendation developed on funding of these programs by Dr. David Satcher, who is president of Meharry Medical College, and Dr. Louis Sullivan, when he was president of Morehouse School of Medicine. He was also principal investigator of an RCMI program. Dr. Satcher spoke at that time as president of the Association of Minority Health Professional Schools.

The recommendation, essentially, was that it is time to set clear, measurable and graduated goals for the involvement of minorities in biomedical research. They recommend serious consideration that within 5 years, some 3.7 percent of NIH budget would go to major minority-targeted programs, and say within 10 years, this should increase to 5 percent.

I think everybody feels in the RCMI institutions that this would go some way to redressing the present situation whereby the percentage of the NIH budget which is directed to minority programs has actually decreased from 0.93 percent in 1985 to 0.86 percent in 1988.

PREPARED STATEMENT

I think the association feels that with 20 percent of our Nation's population as minorities, 3 to 5 percent of NIH's budget devoted to minorities would not seem unreasonable.

Thank you very much indeed for the opportunity to testify for your committee.

[The statement follows:]

STATEMENT OF DR. FRED GREENWOOD

My name is Fred Greenwood and I direct the University of Hawaii's Pacific Biomedical Research Center (PBRC) with a mission to foster interdisciplinary research in the biological and the biomedical sciences in areas such as cell, molecular and neurobiology, Hawaiian evolutionary biology, AIDS research and arbovirology.

THE TRAINING OF HEALTH SCIENCE PROFESSIONALS.

It is axiomatic that an appropriate number of health professionals should be drawn from the minority populations of the U.S.A. The success of programs designed to achieve this goal, undertaken by traditional and non-traditional minority schools with Federal support is a welcome concern of your Subcommittee. The programs at UH undertaking the training of minority students in research are administered by PBRC (1, 2 and 3 below) whilst those focussing on the training of minorities for medical school (4 and 5) and public health (6) are located in the respective schools.

1) Minority High School Student Research Apprenticeship Program (1981-).
2) Minority Biomedical Research Support Program (1974-).
3) Minority Access to Research Careers (1978-).
4) The Imi Ho'ola Program (1973-).
5) Kulia Program (1970-78).
6) Health Careers Opportunity Program (1978-).

The continuation and selective expansion of these minority training programs nation-wide are essential to fully utilize the unique contribution that minority health professionals and researchers can make to the betterment of the health both of the minority populations and for all citizens of this nation. This human resource pool will become of increasing value as the total numbers of young people decline. By the year 2000 there will be 22% fewer 18 year olds and an increased proportion of the school age population will be minority - an estimated 1/3 (Komisaruk, 1989).

THE DEVELOPMENT OF THE INFRASTRUCTURE FOR HEALTH-RELATED RESEARCH.

The number and the quality of minority research students is a function of the number and quality of their research mentors and of the research infrastructure since research and training are inseparable activities.

- *The need for a basic infrastructure: The Research Centers in Minority Institutions Program.*

Traditional and non-traditional minority institutions such as the

University of Hawaii were encouraged by the establishment of the RCMI program at the National Institutes of Health through an appropriation to the Office of the Director in response to authorizing legislation of 1985; the program is administered by the Division of Research Resources. Secretary Heckler's 1985 Task Force on Black and Minority Health cited the relatively poor health status of Blacks and other minorities as compared to the majority population in the United States also noted in the authorizing legislation for the RCMI program. This legislative language acknowledged the historical role that minority institutions have played in developing the range of professionals who provide health care to the minority communities. Implicit in this legislative language is the critical role which these institutions must continue to play in elevating the health status of these communities. This has been an especial concern of your Subcommittee, and continues to be a concern of the communities served by minority institutions. By strengthening the research capability of RCMI-eligible institutions (see Addendum A), we should see a steady progress in our understanding of the health problems that were identified as the causes of the excess deaths in the minority community. In so doing, we will better the health status of all citizens by uncovering new knowledge, the mandate of the National Institutes of Health.

- *The specific need for an AIDS infrastructure: the RCMI solution.*

A new and devastating disease has emerged which makes the participation of minority institutions in National Institutes of Health efforts to achieve its mandated mission more urgent than ever before: the AIDS epidemic. As Admiral Watkins, the Chairman of the President's Commission on AIDS, has indicated, the AIDS problem impacts on our National Security, "...eroding the strength and emotional well-being of our armed forces." Black, Hispanic and other minority communities are now paying a disproportionate price during the AIDS epidemic, for example Blacks and Hispanics constitute some 12% and 6%, respectively, of the U.S. population, but they make up a combined total of 42% of AIDS cases reported to date in the Centers for Disease Control (CDC) AIDS Weekly Surveillance Report. Of the 85,590 cases reported as of February 6, 1989, 27% are black and 15% are Hispanic. Black and Hispanic children under age 13 are tragically and disproportionately impacted by AIDS. They make up 75% of the 1,087 pediatric cases.

The RCMI institutions need support to develop the specific infrastructure to participate in the emerging national needs for addressing the AIDS question. In serving indigenous population they would maintain the historical credibility which these institutions have with their communities and lower the confidentiality barriers which impede attempts to deal with the AIDS problem in Black, Hispanic, and other minority populations. A report documents that the RCMI community has prepared itself by developing a comprehensive plan of attack (Addendum B). Part of this plan includes the acquisition of support for an AIDS infrastructure through the RCMI program and competing for other PHS funds allocated by Congress to address the AIDS epidemic. Several RCMI institutions have been successful in competing for other PHS AIDS funds. However, the major deterrent is the absence of the necessary infrastructure. To this end, applications to the national RCMI Program office have been developed by RCMI institutions for an AIDS infrastructure, and five have been approved by the DRR Advisory Council (October 1988) but still await funding. Meanwhile, four to five additional applications are being developed.

The funding situation for RCMI.

Funding was inadequate in FY 1989 to meet the AIDS initiatives, and the appropriation requested for FY 1990, a 3.4% increase over the 1989 budget of $1.48 million, will need to be increased by an additional $4.42 million if these AIDS initiatives are to be implemented. Minimal extra funds are also needed to cope with inflation and the demands that the RCMI institutions make on the RCMI program staff. Extra professionals and support staff are needed in the RCMI program office, as ten RCMI institutions submit grants in FY 1990 to continue the development of biomedical research, and as noted above, an additional four to five AIDS infrastructure applications are also being developed.

The present.

In summary, the budget recommendation for the Minority Health Initiatives by the RCMI program is as follows:

	President's Request ($ millions)	RCMI Community Recommendation ($ millions)
AIDS	1.532	5.952
non-AIDS	14.313	15.918
TOTALS	15.845	21.870

The future.

These budget recommendations address specific and urgent needs for the next year. But there is need to address the continuing resource needs of the traditional and non-traditional minority institutions in the health arena. The total dollars that have been expended to address the relatively poor health status of our minority citizens, some 20% of our nations population and growing rapidly has fallen far short. The percent of the NIH budget which is directed to minority programs has decreased from 0.93% in 1985 to 0.86% in 1988.

We strongly urge the Congress to adopt the recommendation that Dr. David Satcher, President of Meharry Medical College, made to the Advisory Committee to the Director, NIH, at the June 28, 1988 meeting. His recommendation was subsequently endorsed by the Honorable Dr. Louis W. Sullivan, Secretary of Health and Human Services, in his testimony to the DRS/DRR Reorganization Task Force on behalf of the Association of Minority Health Professional Schools. Dr. Sullivan, at the time of this testimony was President, Morehouse School of Medicine. Their recommendation is:

"It is time to set clear, measurable and graduated goals for the involvement of minorities in biomedical research. I would recommend serious consideration that within five years, at least 3.7% of NIH's budget would go to major minority targeted programs and within ten years, at least 5% of the budget. I would recommend that major efforts be made to strengthen programs that are in place and working such as MBRS, MARC and RCMI. I would recommend that other institutes (of NIH) would emulate the efforts of institutes that have had a major impact upon this problem. I would also encourage NIH and the rest of us to continue to look for new efforts to enhance minority involvement in biomedical research."

Thank you and Aloha.

ADDENDUM A. RCMI awards are already expanding the capacity of the following institutions to contribute to the biomedical research knowledge base and to provide a quality research training environment: Atlanta University (GA), City College-CUNY (NY), Chas. R. Drew University of Medicine & Science (CA), Florida A&M University (FL), Howard University (DC), Hunter College (NY), Meharry Medical College (TN), Morehouse School of Medicine (GA), Ponce School of Medicine (Puerto Rico), Tennessee State University (TN), Texas Southern University (TX), Tuskegee University (AL), Universidad Central Del Caribe (Puerto Rico), University of Hawaii (HI), University of Puerto Rico-Medical Science Campus (Puerto Rico), University of Puerto Rico-Rio Piedras (Puerto Rico), Xavier University (LA).

ADDENDUM B. PROCEEDINGS; SYMPOSIUM ON THE DEVELOPMENT OF AN AIDS INFRASTRUCTURE, editors, F.C. Greenwood, F. Hamilton, F. Jones, S. Opava-Stitzer, 217 pages. A report on a joint meeting of the Research Centers in Minority Institutions and the Asia-Pacific Academic Consortium for Public Health, University of Hawaii, March 1988.

Senator Inouye. The role you have played in fostering minority programs is most commendable, and I can assure you that you have the support of this committee.

Have we had any results in our training programs?

Dr. Greenwood. At the University of Hawaii, just specifically, we have trained in the NBRS program itself 450 minority students over the years.

The success rate in our program is around 70 percent of those students graduating who go on to a health-related career. We lose a few to other professions, but that is the M.D. degree, Ph.D. degree, Master's degree, and health professionals.

The RCMI program has been really crucial, because that allowed us to develop a core facility, for example, for molecular biology.

In 1986, when we got it, only two faculty members could even begin to think of cloning a gene. Now we have 15. They are training students so that they are literate in modern biology.

I have often said that it is no denigration to my zoological colleagues that you can train a Ph.D. to count the number of tree snails in a Hawaiian valley but it is not going to be freely transferrable to modern biotechnology on the mainland.

Senator Inouye. I thank you very much, sir.

STATEMENT OF DR. EDWARD KORMONDY, CHANCELLOR, HILO COLLEGE, THE UNIVERSITY OF HAWAII

Senator Inouye. Our final witness in the Hawaiian contingent is the chancellor of the Hilo College of the University of Hawaii, Dr. Edward Kormondy.

Good to have you here, sir, Mr. Chancellor.

Dr. Kormondy. Thank you, Senator.

It is always a pleasure.

I wish to thank you for the opportunity to present testimony before the subcommittee in support of fiscal year 1990 funding for programs authorized by the Augustus F. Hawkins/Robert T. Stafford Elementary and Secondary School Improvement Amendments of 1989.

My testimony will focus on one program of particular interest to native Hawaiians, namely, a demonstration project for gifted and talented native Hawaiian students. I might say, aside from my testimony, many of the points raised this morning concerning the JTPA program, the nursing program, the MBRS program—they apply equally as well to the Hilo campus.

Title IV, section 4006 of the referenced Secondary School Amendments Act provides that the Secretary of Education shall provide a grant to, or enter into a contract with, the University of Hawaii at Hilo for the establishment of a native Hawaiian Gifted and Talented Center, for demonstration projects designed to address the special needs of native Hawaiian elementary and secondary school students who are gifted and talented, and to provide those support services to their families that are needed to enable such students to benefit from the project.

In my testimony on this program last year, I called attention to a number of socioeconomic conditions facing native Hawaiians, noting that many are amenable to modification through education. But it was also noted that native Hawaiians are severely underrepresented in higher education, with present enrollments being only about 40 percent of what would be expected, given the pool of native Hawaiians available and eligible for higher education.

More disturbing yet are data that we recently gathered on the State of Hawaii's gifted and talented programs in the public schools. Of 5,507 students in the State of Hawaii's Department of Education gifted and talented programs, native Hawaiians constituted only 11 percent of the total—very considerably below their proportion in the general population.

Worse, only 9 percent of the native Hawaiian students enrolled at the elementary level remain into the high school program, as against a total population change of 58 percent.

There is an 81-percent drop in the participation by native Hawaiian children between the elementary and intermediate school levels, and a 46-percent drop between the intermediate and high school levels.

It is evident that the specific needs of these young people are not being met by existing programs. Fortunately, the demonstration project, which is about to be funded at the University of Hawaii at Hilo, is being designed to meet those needs.

There are a number of reasons why the University of Hawaii at Hilo was identified as the location for this demonstration project. These were detailed in last year's testimony, and I will summarize the salient points here.

Native Hawaiians constitute the largest ethnic group of high school students on the island of Hawaii, and more than one-half of all births in Hilo are to native Hawaiians, with the result that this population will dominate the elementary schools for some years.

A gifted and talented program at nearby Waiakea High School, and the demonstrated creativity of the university's native Hawaiian faculty and staff provide rich resources for this project.

Added recognition to the university's leadership in addressing native Hawaiian concerns came in the recently concluded State legislative session in the form of the establishment of a Center for Hawaiian Language and Culture at the University of Hawaii at Hilo, the purpose of which is to preserve the Hawaiian language and culture and to develop curricular materials on Hawaiian language and culture for the schools.

That center and the gifted and talented project will obviously have great interrelationships.

Although the project has yet to be funded, we have been preparing for it during the past year in three ways: First, collecting information on gifted and talented issues; second, identifying resources and prospective collaborators; and third, identifying potential strategies and activities.

I will elaborate briefly on each of these components.

With regard to collecting information, we have been collecting information about gifted and talented programs and education issues of Hawaiian children from national, State, and local sources. A statewide conference focusing on Hawaiian education issues related to gifted and talented programming was held on the campus this past year.

The principal investigator attended a workshop in a multicultural symposium on exceptional children, and conferred with gifted and talented program directors, particularly those working with native Americans and other disadvantaged groups.

Key individuals, groups, and organizations that will be important to effective execution of a gifted and talented program have been identified. At the national level, recognized experts in exceptional children include, among others, Barbara Clark of California State University at Los Angeles; Douglas Prillaran, College of William and Mary; and Stuart Tonemah, American Indian Research and Development, Inc.

At the State level, resources include, among others, the Department of Education gifted and talented program, and the State gifted and talented advisory committee; Queen Liluokalani Children's Center; the Kohule project, Alulike, Inc., and the Kamehameha Schools; and the Office of Hawaiian Affairs, and the magnet schools and learning centers.

At the university itself, faculty and staff in several programs, such as Upward Bound and the secondary school training program will be engaged in the project.

Meetings with these resource personnel and organizations are being scheduled for the coming summer.

The primary focus in identifying potential strategies and activities to improve the identification of gifted and talented native Hawaiian youngsters has been going forward. Once identified—and they are significantly underidentified, as I noted before—among the activities being considered to nurture those gifts and talents are the development of middle school and high school leadership programs modeled after our successful program at the university level, and adapted to the social, cultural, and family needs of the Hawaiian students; video and other educational technologies for use in the schools and at home; special summer programs in the arts, sciences, and other fields; and importantly, teacher training courses and teacher workshops dealing with gifted and talented children.

PREPARED STATEMENT

In summary, Mr. Chairman, I indicate my strong support for continued funding of this project, which is designed to enable more native Hawaiians to assume their rightful role in contemporary society.

We thank you.

[The statement follows:]

STATEMENT OF DR. EDWARD J. KORMONDY

Mr. Chairman and Members of the Committee, I wish to thank you for the opportunity to present testimony before the Subcommittee in support of Fiscal Year 1990 funding for programs authorized by the Augustus F. Hawkins - Robert T. Stafford Elementary and Secondary School Improvement Amendments of 1989. My testimony will focus on one program of particular interest to Native Hawaiians, namely a demonstration project for gifted and talented Native Hawaiian students.

Title IV, Section 4006 of the referenced Act provides that the Secretary of Education shall provide a grant to, or enter into a contract with, the University of Hawaii at Hilo for the establishment of a Native Hawaiian Gifted and Talented Center at the University for demonstration projects designed to address the special needs of Native Hawaiian elementary and secondary school students who are gifted and talented and to provide those support services to their families that are needed to enable such students to benefit from the project.

Educational Needs of Native Hawaiians

In my testimony on this program last year, attention was called to a number of socio-economic conditions facing Native Hawaiians, noting that many are amenable to modification through education. But, it was also noted that Native Hawaiians are underrepresented in higher education with present enrollments being only 40 percent of what would be expected given the pool of Native Hawaiians available and eligible for higher education. More disturbing are data we gathered on the State of Hawaii's gifted and talented programs in the public schools.

Of 5,507 students in the State of Hawaii's Department of Education gifted and talented programs, Native Hawaiians constituted only 11 percent of the total, very considerably below their proportion in the general population Worse, only 9 percent of the Native Hawaiian students enrolled at the elementary level remain into the high school program as against a total population change of 38 percent. There is an 81 percent drop in participation by Native Hawaiian children between the elementary and intermediate school levels and a 46 percent drop between the intermediate and high school levels.

It appears evident that the specific needs of these young people are not being met by existing programs. Fortunately, the demonstration project which has just been funded at the University of Hawaii at Hilo is being designed to meet those needs.

Justification for the Native Hawaiian Gifted and Talented Center to be Located at the University of Hawaii at Hilo

There are a number of reasons why the University of Hawaii at Hilo was identified as the location for this demonstration program. These were detailed in last year's testimony, and I will but summarize the salient points here. Native Hawaiians constitute the largest ethnic group of high school students on the Island of Hawaii, and more than half all births in Hilo are to Native Hawaiians with the result that this population will dominate the elementary schools for some years. A gifted and talented program at nearby Waiakea High School and the demonstrated creativity of the University's Native Hawaiian faculty and staff provide rich resources for the project.

Added recognition of the University's leadership in addressing Native Hawaiian concerns came in the recently concluded state legislative session in the form of the establishment of a Center for Hawaiian Language and Culture at the University, the purpose of which is to preserve the Hawaiian language and culture and to develop curricular materials on Hawaiian language and culture for the schools.

Accomplishments of the Project

Although the project was but recently funded, we have been preparing for it during the past year in: 1) collecting information on gifted and talented issues; 2) identifying resources and prospective collaborators; and 3) identifying potential strategies and activities. I will elaborate briefly on each of these three components.

1. Collecting Information. Information has been collected about gifted and talented programs and education issues of Hawaiian children from national, state and local sources. A state-wide conference focusing on Hawaiian education issues related to gifted and talented programming was held on the campus. The principal investigator attended a workshop and a multicultural symposium on exceptional children and conferred with gifted and talented program directors, including those working with Native Americans and other disadvantaged groups.

2. Identifying Resources and Prospective Collaborators. Key individuals, groups and organizations that will be important to effective execution of a gifted and talented program for Native Hawaiians have been identified. At the national level, recognized experts in exceptional children include, among others: Barbara Clark, of California State University, Los Angeles; Douglas Prillaran, College of William and Mary; and Stuart Tonemah, American Indian Research and Development, Inc. At the state level, resources include, among others: the Department of Education Gifted and Talented Program and the State Gifted and Talented Advisory Committee; Queen Liliuokalani Children's Center; the Hokule'a project; Alulike, Inc.; Kamehameha Schools; Office of Hawaiian Affairs; and Magnet Schools/Learning Centers. At the University itself, faculty and staff and several programs such as Upward Bound and the Secondary School Training Program will be engaged in the project.

Meetings with these resource personnel and organizations are being scheduled for this summer.

3. Identifying Potential Strategies and Activities. The primary focus of our efforts has been on developing strategies to improve the identification of gifted and talented Native Hawaiian youngsters. Once identified, the activities being considered to nurture those gifts and talents include, among others: middle school and high school leadership programs, modeled after our successful program at the university level, and adapted to the social, cultural and family needs of the Hawaiian students; video and other educational technologies for use in the

schools and at home; special summer programs in the arts, sciences, and other fields; and teacher training courses and teacher workshops dealing with gifted and talented children.

Concluding Statement

In summary, Mr. Chairman, I indicate my strong support for continued funding of this project which is designed to enable more Native Hawaiians to assume their rightful role in contemporary society.

Senator **Inouye**. Thank you very much, Doctor.

What do you attribute this underidentification of native Hawaiian gifted and talented children to?

Dr. **Kormondy**. People who advise me on the project indicate that the tendency is to use the standard tests and measurements that are largely geared to highly literate, highly skilled use of the English language, mathematical skills, and the like.

The counterpart at the college level would be the SAT, or the American College Testing Program.

Our people say that our native Hawaiian youngsters do not test well under those circumstances, and thus we will need to identify other strategies for identifying those youngsters.

Senator **Inouye**. Are you working on those strategies now?

Dr. **Kormondy**. Yes; we are, and taking advantage of some of those experts who have dealt with other minority populations, native American populations, who also find exactly the same sad result: That is, underidentification through the standard tests and measurements.

So, we will take advantage of their experience and knowledge to develop new means of identifying these youngsters, and then finding ways of encouraging them to continue, right on through the high school years.

Senator **Inouye**. I thank you very much.

Mr. **Akaka**. Thank you, Mr. Chairman.

I just want to say thank you for coming, and thank you for your testimony.

I know you have worked hard on the project out there, and we are looking forward to it blossoming into good use.

Thank you.

Dr. **Kormondy**. Thank you.

Senator **Inouye**. Thank you, sir.

STATEMENT OF HOWARD J. SILVER, EXECUTIVE DIRECTOR, CONSORTIUM OF SOCIAL SCIENCE ASSOCIATIONS

Senator **Inouye**. Our next witness is the executive director of the Consortium of Social Science Associations, Howard J. Silver.

Mr. Silver. Welcome, sir.

Mr. **Silver**. Good morning, Mr. Chairman.

I am Howard J. Silver. As you said, I am the executive director of the Consortium of Social Science Associations, or COSSA, which represents 185,000 American scientists across the broad spectrum of the social and behavioral science disciplines, many of whom conduct research on labor force and labor markets.

Every day we read and we hear about the new diversified workforce and the new workplace. Changing demographics and changing retirement patterns will transform the picture of who works in America. The need to remain competitive in an interdependent world economy has altered the way America's businesses and firms operate.

We believe full funding for research and evaluation at the Employment and Training Administration and the collection and analysis of data at the Bureau of Labor Statistics is imperative if we are able to understand these changes and help decisionmakers determine policies to cope with them.

In the brief time I have this morning, I would just like to go over some of the recommendations we make in our testimony that was submitted to the record.

We ask the subcommittee to support ETA research to follow up on the continuing changes in the work force identified in the ETA sponsored project Workforce 2000. These include the increasing share of women and minorities as entrants into the labor force, the economy's need for workers with higher level of skills, and programs for resolving conflicts between work and family, including day care and parental leave.

The effect of these changes requires research and evaluation to assess their impact on America's economic sets.

We also ask the subcommittee to support the revival of an ETA sponsored dissertation grant program, which from 1968 until 1984 provided funds under which more than 500 Ph.D. candidates produced dissertations on various aspects of labor market performance and policy.

It is clear that it is time to attract and recruit new people into the employment and training field if it is going to remain vitally important to decisionmakers for this country's economic future.

We also ask the subcommittee to fully fund the Bureau of Labor Statistics, so that it can carry out its redesign of the current population survey, making it a longitudinal database to enhance its value to all who use it to make decisions and forecasts.

We ask this subcommittee to give BLS sufficient funds to continue the collection and analysis of data of the National Longitudinal Study of Labor Market Experiences, a national treasure trove of information that follows cohort groups over time.

The NLS has a 1979 Youth Cohort which, unique to this survey, permits a person's comprehensive employment history to be known. It also has a children of NLS mothers data set, which, if continued, could provide a comprehensive view of the process of child development from infancy through adolescence.

Finally, we urge the subcommittee to support a new health and retirement survey, last conducted in 1979. This survey will answer questions about retirement plans of the labor force, the impact of health concerns and pension plans on the decisions to retire, and the potential productivity of older workers.

The National Institute on Aging has indicated interest in reviving this survey, but it needs support and funding help from other agencies, including those in the Department of Labor.

There is much more that could be put on a labor research agenda. Research on family composition, the continuing impact of women on work, business response to child care needs, and adolescent learning of the work ethic are all issues which require systematic examination.

Figuring out ways to make those we now call the underclass productive working citizens in our society is another area which should be pursued.

We also need more research on changes in the workplace. How are the new styles of management, new methods of pay and compensation, including pension plans, affecting productivity?

We urge the subcommittee to support ETA research and evaluation, and BLS data collection and analysis, to help you in Government and those in the private sector who are going to make the decisions that will affect the economic future of the United States.

I thank you for this opportunity for us to present our views.

[The statement follows:]

STATEMENT OF HOWARD J. SILVER

I am Howard J. Silver, executive director of the Consortium of Social Science Associations (COSSA). COSSA represents 185,000 American scientists across the broad spectrum of the social and behavioral science disciplines. A list of COSSA members, affiliates and contributors is attached to my testimony.

I appear before you today to discuss the budgets for research, evaluation, and statistics at the Department of Labor, in particular the Employment and Training Administration (ETA) and the Bureau of Labor Statistics (BLS). COSSA recommends full funding of $18.4 million for the research and evaluation program at ETA under Title IV-D, the National Activities Section of the Job Training Partnership Act (JTPA). We also urge full funding of direct appropriations of $193.2 million at BLS.

Every day in the popular press we read about the diversified workforce and the new workplace. Changing demographics and changing retirement patterns will transform the picture of who works in America. The need to remain competitive in an interdependent world economy has altered the way America's businesses and firms operate. Support for research and evaluation at ETA and the collection and analysis of data at BLS is imperative if we are to understand these changes and help decision-makers determine policies to cope with them.

EMPLOYMENT AND TRAINING ADMINISTRATION (ETA)

In recent years, the budget for research and evaluation activities at ETA has remained quite low by historical standards despite Congress' correct position that the research function in ETA is essential for making intelligent employment and training policies. JTPA, passed in 1983, clearly states:

> To assist the nation in expanding work opportunities and assuring access to those opportunities to all who desire it, the Secretary shall establish a comprehensive program of employment and training research, utilizing the methods, techniques, and knowledge of the behavioral and social sciences and such other methods, techniques and knowledge as will aid in the solution of the Nation's employment and training programs.

Workforce 2000, an ETA-sponsored project, has already begun to identify current and projected workforce changes -- the increasing share of women and minorities as entrants into the labor force, the economy's need for workers with higher level skills, and programs for resolving conflicts between work and family, including day care and parental leave. The effect of these changes, all tied to the nation's need to increase productivity, will require research and evaluation to assess their impact on America's economic success.

ETA's research portfolio includes experimental evaluations of the Job Training Partnership Act (JTPA). Unfortunately, budgetary decisions already have shortchanged these evaluations by eliminating longitudinal data collection on JTPA participants. Scientifically sound evaluations are made tougher when forced to start in the middle of an ongoing program. ETA must have sufficient funds to permit adequate samples sizes for and random assignments to evaluation experiments so that the conclusions will have validity and reliability.

From 1968 until 1984, ETA funded a doctoral dissertation grant program under which more than 500 Ph.D. candidates produced dissertations on various aspects of labor market performance and policy. Over the past twenty years, a substantial fraction of the best known and best respected labor market researchers have received help in starting their careers from this now defunct program. There are indications that the employment and training field needs new blood. The revival of the dissertation grant program would help recruit new people into a field that is going to remain vitally important to decision-makers for this country's economic future.

We also urge the Subcommittee to provide ETA sufficient funds to allow the Commission on Workforce Quality and Labor Market Efficiency, appointed by former Secretary Ann McLaughlin, to finish its important research-based work. The commission, a mix of distinguished academic researchers, business executives, and labor representatives, has gathered research papers on 40 separate topics -- Education, Training, Unemployment and Job Search, Labor Force Participation of Various Groups, Flexibility Issues, and Strategies for Productivity Enhancement -- in an effort to seek ways to substantively improve the employment and training system. Public hearings will be held to follow up on the papers.

We support ETA's request for $18.4 million in FY 1990 for research and evaluation. This level was requested in FY 1989, but reduced by the Congress to $13.4 million. We are disturbed, however, that the ETA request includes an OMB-mandated earmark of $5 million for an evaluation of the Job Corps program. This is yet another example of OMB intrusion into the information collection and research agendas of the federal agencies. OMB has done this repeatedly using its clearance power under the Paperwork Reduction Act in a way that has delayed and stifled the collection of information that helps policy makers choose among alternatives. The Job Corps may need evaluation, but $5 million is insufficient to do the job right and the ETA has more important items on its research and evaluation agenda. COSSA urges you to include report language deleting this earmarking by OMB for the Job Corps evaluation and asks you to fully fund ETA so that they can get on with their own important research and evaluation agenda developed by the professional staff.

BUREAU OF LABOR STATISTICS (BLS)

In order to understand the new workforce and workplace, accurate and usable data are needed to provide information for decision-makers. The Bureau of Labor Statistics is the major information source for these data. BLS needs support for its planned redesign of the Current Population Survey (CPS). Improving the CPS and adding a longitudinal dimension to it would enhance its value for all who use the survey to base their decisions and forecasts.

The National Longitudinal Survey of Labor Market Experiences (NLS) is a BLS-housed data collection effort that follows cohorts of people overtime. In the early 1980s, COSSA along with others lobbied hard to stave off the total elimination of NLS. Thanks to Janet Norwood, Commissioner of BLS, NLS found a new home and survived. Yet, it has not prospered. Budget cuts forced it to eliminate two of the original cohorts -- old men and younger men. Gramm-Rudman-Hollings reductions further eroded the NLS' ability to reinterview its respondents. A recent conference sponsored by the National Science Foundation to discuss the future of the NLS concluded that this survey should be continued with focus on reinterviewing the 1979 youth cohort which unique to this survey permits a person's comprehensive employment history to be known; continuing the Children of NLS Mothers data set which, with support from the National Institute of Child Health and Human Development (NICHD), could provide a comprehensive view of the process of child development from infancy through adolescence; and beginning a new youth cohort. We urge the Subcommittee to give the BLS sufficient funds to continue funding for this national treasure of information.

As the American work force continues to grow older, the nation needs to discover answers to questions about retirement plans of the labor force and the impact of health concerns and pension plans on those decisions. It also needs to explore the productivity potential of older workers. These were all important aspects of what a COSSA-sponsored breakfast seminar, "Older Workers in an Aging Society," examined last year. One way to explore these issues would be to support the renewal of the Retirement History Survey, last conducted in 1979. The National Institute on Aging (NIA) has indicated interest in reviving this survey, but it needs support and funding help from other federal agencies, including those in the Department of Labor. COSSA asks the Subcommittee to commit itself to supporting a new Health and Retirement History Survey.

CONCLUSION

There is much more that could be put on a labor research agenda. Research on family composition, the continuing impact of women on work, business response to child care needs, and adolescent learning of the work ethic are all issues that require systematic examination. Figuring out ways to make those now considered part of the underclass, productive working citizens in our society is another area that should be pursued. How important is migration to the necessary redeployment of our labor force? Why don't people move to where the jobs are? These are just some of the topics involving the changing nature of the workforce.

We also need more research on changes in the workplace. How are the new styles of management, new methods of pay and compensation, including pension plans, affecting productivity? Data at the level of the firm is necessary to organize analyses that can reach down to the micro level of worker and firm, not just the macro level of the industry on which so much of our research is based.

We urge the Subcommittee to support ETA research and evaluation and BLS data collection and analysis to help you in government and those in the private sector who are going to make the decisions that will affect the economic future of the United States.

Thank you for this opportunity for COSSA to present its views.

Senator **Inouye**. I thank you very much, Mr. Silver.

Your prepared text has a paragraph opposing OMB's evaluation of the Job Corps. Why?

Mr. **Silver**. We have been led to believe that the $5 million earmark that OMB has put in for the evaluation is not sufficient to do an adequate job, and if Congress and the executive branch really want a sufficient evaluation of the Job Corps, more money is needed.

We also oppose it because it represents another attempt by OMB to intrude itself onto setting the research agendas of the departments. There is evidence across the Government of OMB using its clearance procedure under the Paperwork Reduction Act to deter surveys, to change questions in surveys, and to intrude itself onto the research agendas of the departments.

There is a long-awaited study by the General Accounting Office, asked for by the House Science Committee, which we hope will be out soon, that will document some of this.

Senator **Inouye**. Thank you very much, sir.

STATEMENT OF PIERCE A. QUINLAN, EXECUTIVE VICE PRESIDENT, NATIONAL ALLIANCE OF BUSINESS

Senator **Inouye**. Our next witness is the executive vice president of the National Alliance of Business, Pierce A. Quinlan.

Mr. Quinlan. Welcome, sir.

Mr. **Quinlan**. Thank you, Mr. Chairman. I appreciate it. I appreciate the opportunity to testify on the fiscal year 1990 appropriations for the Department of Labor.

The National Alliance of Business is a business organization that is taking a unique step, Mr. Chairman, in testifying in support of Federal funding for programs related to job training, because the business community is becoming increasingly aware of the importance of this investment in meeting the needs of our changing labor market.

We are also extremely aware of the budget constraints that you are operating under, but felt that it was time now to speak out, because a major gap is developing between the emerging job opportunities that we are creating at great volumes in this country and the qualifications of available workers.

I think my detailed testimony talks about examples of the difficulty that employers are having in finding workers, and not in that testimony, but a recent example of Bell South in Atlanta, interviewing as many as 60 individuals to find one customer service representative gives an indication of the kinds of gaps that are being created, because our jobs are more complex. They require better basic skills and reasoning skills.

But in the future years, as we have been talking about, about 82 percent of the new entrants into the labor force will be women and minorities, and these are the groups that have traditionally had difficulty adjusting to the labor market.

At the present time, over 40 percent of the dropouts from our schools—40 percent of our young black youngsters drop out from schools, and over 50 percent of our Hispanic youngsters drop out. So, we have really a need for a two-pronged effort. One prong is to restructure our schools so that we are not having that kind of performance come from the school systems, and a lot of work is being done on that by a lot of people in partnership with one another.

But we also have to continue the employment and training programs, because the second chance systems are necessary for the foreseeable future, until we bring about some changes in the first chance programs. They really must be seen as an investment, not really an expenditure. They are really key to our future competitiveness.

There is no question that the business community must spend a great deal of money itself in increasing the skills of its own employees, but it cannot go it alone. Businesses spend approximately $30 billion per year on formal training programs, but there are estimates by the American Society for Training and Development that they would have to spend as much as $25 billion more per year, just to meet the remedial education needs of the employees.

These are funds that really could be devoted to research and development and other sorts of activities, including upgrading existing workers.

So, basically, our position is the Federal Government must continue and really expand the investment in the work force as a part of a partnership between State and local governments, the business community, and the Federal Government.

Specifically, we believe that funding for the job training partnership program, including the Dislocated Worker Program, should be increased. Since 1983, there has been essentially level funding of JTPA, and de facto, as Senator Simon mentioned this morning, we have had a 22 to 25 percent decrease in the ability of the programs to serve individuals because of the impact of inflation.

As it was, in 1983, the JTPA program could at best serve about 5 percent of the universe of need, and now, with the effect of inflation and the focus on serving even more hard-to-serve individuals, that percentage will undoubtedly go down.

A second concern we have is that with the passage of the act that dealt with dislocated workers, the points that were made by the Senators earlier—we are concerned that there be adequate financing for the Dislocated Worker Program. We are not convinced that the administration's level is adequate with that level, and we were very concerned and involved in the enactment of the welfare reform legislation, the first time in two decades in this country that we have really begun to focus on the employment needs of people on welfare.

We are very concerned that the resources that are being requested by the administration for the jobs program are adequate.

So, what we have done as an organization is to join with the nine other key organizations—State and local government organizations, and employment service and public welfare agencies—to request sufficient fundings for these programs.

These programs would include a whole range of efforts, including the Employment Service, the Job Opportunity Program for Welfare Training, for the JTPA program, and so on.

We believe that not only should these programs be level funded, but there should be some provision for inflationary considerations—the impact of inflation.

Without that, we end up serving fewer and fewer people every year. So, therefore, I would urge consideration for the range of programs that are on the books, plus particular attention to the new programs that were approved this past year—the Welfare Reform Training Program and the Dislocated Worker Program—that there be an increase over the level that the administration has recommended today.

We are concerned that if the programs are not adequately financed in the early stages, that those programs may not be successful. We are now building on a period of success. The JTPA program, for example, we believe has been very successful. It is cost-effective. It is in need of reexamination, and the Congress is looking at that. But without adequate financing, we are concerned that we are going to be able to keep the involvement of all of the partners, particularly in the business community, the 10,000 business volunteers who serve on private industry councils—if they are faced with a decreasing amount of money de facto, keeping their attention is likely to be more difficult than it even has been to date.

So, Mr. Chairman, that is the testimony of the National Alliance of Business.

[The statement follows:]

STATEMENT OF PIERCE A. QUINLAN

Mr. Chairman, I appreciate the opportunity to testify before the committee on the Fiscal Year 1990 appropriations for job training and related program investments directed at improving the quality of nation's workforce.

I am Pierce A. Quinlan, Executive Vice President of the National Alliance of Business. The Alliance is the only national business organization which concentrates on the specific areas of job training, education, and human resource development policies, primarily for the nation's unemployed and disadvantaged. We advocate effective involvement of business in public programs through public/private partnerships in communities across the country.

We have taken this unique step, as a national business organization, to testify in support of federal spending for programs related to job training and workforce competitiveness because business leaders are increasingly aware of the importance of this investment to meet the needs of our changing labor market.

The Problems of Workforce Quality

America's competitive advantage increasingly depends on the skills, knowledge, and flexibility of its workforce. The jobs that are being created now are more complex, requiring better reading, writing, mathematical, communications, and reasoning skills. However, there are indications that a gap exists between the emerging job opportunities and the qualifications of available workers, particularly among the bottom half of the workforce in terms of educational achievement and training. Evidence suggests that this trend will only get worse over the next few years because entry level workers will increasingly be drawn from this population pool.

The most telling evidence of a skills gap comes from businesses, which are already having difficulty finding qualified job applicants. Based on a survey we conducted last year, two-thirds of private employers consider the current pool of entry-level applicants to be insufficiently prepared in basic skills. At the New York Telephone Company, only 20 percent of applicants taking an operator's test pass. Motorola finds that only 20 percent of its applicants can pass a simple 7th grade English comprehension or 5th grade math test. And when the IBM Corporation installed millions of dollars worth of new computerized equipment in its plants in Vermont, it had to set up classes in high school algebra for thousands of production employees before they could operate the equipment.

Employers are practically unanimous in their concern that the competencies of entry level workers are deficient. The National Assessment of Educational Progress assessment of the literacy skills of young adults ages 21 to 25 confirms business' assertions, finding that sizeable numbers were unable to do well on tasks of even moderate complexity. Three out of five 20-year-olds in our country could not get from point A to point B on a map; three out of five could not add up their bill after lunch and did not know if they were given correct change; and while three out of five could read the lead article in a newspaper, they could not reiterate its salient points.

Job Training and Productivity

Business is coming to view employment and training programs as part of a necessary national strategy to restore productivity growth, which in turn is a critical determinant of the nation's standard of living. Individual companies have a profound interest in finding ways to restore productivity growth, since their very survival depends on it.

In the 15 years since 1973, productivity (measured as output per hour of labor) has increased an average of 1 percent per year, compared to 2.7 percent over the previous 15 year period. A more important comparison in today's economy, however, is how U.S. productivity statistics stack up against those of other industrialized countries. The statistics show that in virtually every case U.S. productivity growth has been below our major trading partners. Any country whose productivity growth consistently lags behind that of other countries must eventually experience a relatively lower standard of living.

We are already beginning to see some signs of that decline in living standards. Growth in family incomes in this country has virtually stalled since 1973, despite the fact that families have sent additional earners into the workforce, delayed having children, and gone into debt to maintain improvements in their standard of living.

Economists differ on how to solve the productivity problem, but there is a growing consensus that improving the quality of American workers is becoming an increasingly critical factor. Edward Dennison, an expert in growth economics, has estimated that one-third of the nation's economic growth since World War II can be attributed to increases in the education and skills of the American workforce. Another one-half of the growth resulted from technological innovation and increased know-how, which required an educated and skilled workforce for continued development and application.

The Need to Invest in Education and Training

The necessary investment in worker education and training is too great for business to handle on its own. American corporations currently spend an estimated $30 billion on formal training programs for employees. The American Society for Training and Development (ASTD) predicts that these corporations will have to spend as much as $25 billion yearly on remedial education alone. Currently, Motorola must spend 60 percent of its employee training budget on remedial education in basic math and reading skills.

It may be impressive that businesses are investing billions of dollars in education and training, but the important point is that these funds could be put to more productive uses, such as research and development and investments in modern new equipment to increase the nation's competitive edge. The problem is most acute for small businesses that rarely have much of a training budget to begin with, and are forced to make do with whatever workers are available to them. Ironically, the nation is counting on small businesses to lead the way with new job creation.

There is a growing consensus among business leaders on the need for greater investment in our nation's human resources. Employment and training programs are becoming a matter of national priority in our continuing efforts to improve the competitive posture of our workforce in the world market. Yet federal investments in this critical area lag substantially behind the rising demand for public employment and training services.

The Federal Response to This Problem

Our primary interests center on federal investments in several programs which constitute the government's primary response to issues of unemployment and workforce quality. Our organization works very closely with the Job Training Partnership Act programs, including the new Economic Dislocation and Worker Adjustment Assistance (EDWAA) Act program of 1988, and the new Job Opportunities and Basic Skills (JOBS) program under the Family Support Act of 1988. We feel it is critical that funding for these programs be increased.

Together with nine other key national organizations, representing a coalition of governors, state legislatures, counties, mayors, cities, and employment security and public welfare agencies, we are also requesting at least enough funds to keep up with current levels of services in the remaining core of programs in this area: the public employment service under the Wagner-Peyser Act, Carl D. Perkins Vocational Education Act, Adult Education Act, Older Americans Community Service Employment Act, Food Stamp employment and training assistance, training funds for the homeless under the Stuart B. McKinney Act, Trade Adjustment Assistance training and relocation activities, and the federal-state unemployment insurance system; the transitional Work Incentive (WIN) program; and administrative support for the Targeted Jobs Tax Credit program.

The federal investment in these areas of spending has declined consistently over the recent decade. For example, in 1983 the amount of funds provided through federal appropriations for programs under the Job Training Partnership Act, particularly the grants to states and local service delivery areas for training economically disadvantaged individuals, were sufficient to serve on average of about 5 percent of the eligible population. Now JTPA programs are able to accomplish only three fourths of what they could do in 1983, because of reductions in appropriations and inflation costs. In today's tight labor markets, these programs must increasingly focus on harder to serve individuals, further raising program costs and reducing the numbers served.

In the last two years, substantive legislation has expanded the services and responsibilities in seven of these programs. However, the level of funding for those seven new initiatives has not increased with the added expectations and responsibility. Congress has made substantial commitments in the authorizing statutes, but has not followed through consistently with the strategic funding commitments.

Just last year, Congress placed a high priority on two new initiatives that establish comprehensive programs of assistance to dislocated workers and to welfare recipients, to provide them with necessary education, training, and transition assistance into jobs.

Yet, this year there is little prospect that these programs will be funded near authorized levels, limiting their potential impact, and possibly setting them up to fail.

The Problem Is Expected to Grow

We are convinced that these programs will take on even greater importance in the coming years. The increasing poverty rate among American children, which has risen from 14 percent in 1973 to 20 percent today, could undermine the productivity of future workers. Children brought up in poverty are three to four times more likely to drop out of school than their more affluent peers. More than three-fourths of all poor youths have poor basic skills. Thus, children brought up in poverty are more likely to remain poor as adults. Unless the federal government sustains its commitment to reducing poverty through investments in the education and skills of poor citizens, the existing shortage of qualified workers could worsen significantly in the years ahead.

Much of this expense would be unnecessary if the public schools would do their job right the first time. Substantial efforts are underway to solve these problems locally by restructuring education. But education reform is by nature a long term project. In the meantime, young people, particularly poor young people, are continuing to drop out of school and out of a meaningful future in the economy. In my view, the long term prospect of education reform argues the case for increased investment in these second-chance programs rather than a diminished need for them.

Renewed Federal Commitment to Invest in Job Training and Workforce Quality

This is the first time that business leaders and elected officials have felt compelled to convene around these issues. We are committed to stay together and work together to ensure an adequate investment in the future of our workforce, particularly for the disadvantaged and unemployed in our population.

I urge you, at a minimum, to ensure a federal commitment for appropriations levels in these core programs that would account for level funding plus inflation. This would at least allow us to continue current levels of services. This request is tempered only by respect for the difficult decisions needed on the deficit. Clearly the need for services under these programs is much greater than current funding will provide. However, the long term trend in this area of appropriations must be upward.

I urge the committee, likewise, to provide adequate funding levels for the two new education and training initiatives enacted last year for dislocated workers under title III of the Job Training Partnership Act, which was enacted as part of the trade reform bill, and for welfare recipients under title II of the Family Support Act of 1988, which we are now helping to implement in partnership with state and local elected officials. The minimal funding levels requested in the President's budget, $400 million and $350 million respectively, may be too minimal for starting up credible nationwide programs. In my view, it would be a mistake to miss this historic opportunity to provide education and training for individuals who can overcome dependency on other entitlements and become self sufficient, at a time when competent entry level workers are so desperately needed in the economy.

Thank you, Mr. Chairman. I would be happy to answer any questions you or other members of the Committee might have.

Senator INOUYE. Your contention is that if we do not keep up the funding, the JTPA program will not be cost effective?

Mr. QUINLAN. No, sir; it is not.

I think the program is cost effective, but the ability to—we are serving such a small proportion of the eligible population as it is, the ability to continue to serve that is being cut by the attrition of inflation.

So, if we were able to serve 5 percent in 1983, the likelihood is that we will be down around 3 percent in 1989 or 1990.

At the same time, we are still having one million dropouts from schools per year—which would mean that the numbers of individuals who are needing services from the second chance systems are going up, and the ability of the system to serve these individuals are either static or going down, depending on the impact of inflation.

Senator INOUYE. I wish to commend you, Mr. Quinlan, and your organization, for participating in our proceedings here.

We very seldom see the business community involving itself in matters such as training, so I thank you very much for it.

Mr. QUINLAN. Thank you, Mr. Chairman.

We believe it is an investment, not an expenditure.

Senator INOUYE. Thank you, sir.

STATEMENT OF DAVID MARANVILLE, DENISON JOB CORPS CENTER, IOWA

Senator INOUYE. Our next witness is from the Denison Job Corps Center in Iowa, David Maranville.

Did I pronounce your name correctly, sir?

Mr. MARANVILLE. Mr. Chairman, the Job Corps community sincerely appreciates this opportunity to appear before you today to submit facts concerning funding needs for the Job Corps Program in fiscal year 1990.

As Job Corps celebrates its 25 year anniversary, it is appropriate to review what has helped this program to survive for 25 years. Job Corps returns $1.46 to the Government for every $1 spent on the program.

Our placement rate in 1987 rose to 84 percent. This rate was achieved with enrollees who, on the average, are economically disadvantaged 18-year-old high school dropouts, reading at or below a sixth grade level.

The Job Corps 25th anniversary slogan states that Job Corps provides a chance for change. Over 1.4 million youths served since 1964 have found this to be true.

Mr. Chairman, there are three items that I would like to discuss today. We will discuss the administration's fiscal year 1990 budget request as it pertains to Job Corps, the Job Corps community program goals for fiscal year 1990, and a pending fiscal year 1989 $24 million operations shortfall.

Mr. Chairman, although the adminstration's budget recognizes Job Corps as a vital force in the education and training of this country's youth, it does not adequately confront the realities of operating this national program.

The administration budget request proposes a funding level of $761 million for the Job Corps fiscal year 1990 budget, an increase of approximately $20 million from last year.

According to the Department of Labor, this amount will be enough to maintain current Job Corps operations. This, however, is not the whole picture.

In fact, what appears to be a modest increase for Job Corps is an inadequate amount. The administration's figure is based on faulty assumptions. OMB's proposal of $761 million will be sufficient only if its questionable assumptions hold true.

Assumption: Inflation for program year 1990 is held to 3.4 percent. The Congressional Budget Office estimates inflation in 1990 will approach 4.2 percent. A projection of 3.4 percent is inadequate, and could prove costly to Job Corps.

A case in point: This year Job Corps faces a $24 million shortfall because DOL limited its inflationary projection last year to just 2 percent.

The proportion of reliable, nonresident slots is increased from 10 percent to 20 percent. The Department of Labor plans to exchange 4,000 residential slots for 4,000 less costly, nonresidential slots.

This assumption strikes at the heart of what makes our program different from other employment and training programs. The centers take youths out of environments that are often filled with hostility, family strife, drug abuse, and places them in a highly disciplined living environment.

Some 600 Job Corps II slots are eliminated or kept in place at the expense of eliminating equal numbers of slots at existing centers. Over 4 years of effort have gone into these pilot programs, many of which are just beginning to come to fruition. It would be a complete waste of time, effort, and money to reduce these programs now.

An accrual of money savings from Job Corps II programs is assumed. Many of the Job Corps programs are just beginning to show the results, and OMB is basing its projections upon savings having been generated—but little information is available that would pertain to these Job Corps II savings.

Job Corps does have significant program needs that we hope will be considered in your deliberations this year. We have pooled our collective experience and are proposing three program goals for fiscal year 1990. We seek your help in making these goals a reality.

Continued services to corps members at existing centers, without closing dormitories to eliminate residential slots—it would be harmful to reduce a program which has proven to be one of the best ways to provide America's neediest youth with education, training, and residential living.

The administration budget proposal assumes $12 million in savings by closing dormitories in unspecified Job Corps II efficiencies. We estimate approximately $770.4 million will be needed to maintain operations at current levels in fiscal year 1990.

Continue to relocate centers that are at facilities no longer conducive to learning—it takes a special environment to educate and train the type of youth that are enrolled in Job Corps. These centers desperately need to be relocated to facilities more suited to educating and training at-risk youth.

An appropriation of $15 million in fiscal year 1990 is required to continue the process of relocating centers in need of more appropriate facilities.

I might point out, Mr. Chairman, I had the pleasure of being in both Oahu and Maui 3 weeks ago when we dedicated the new Maui Job Corps Center. Our company operates the two Hawaii Job Corps Centers.

Provide targeted funding to establish and maintain research and development initiatives to improve program efficiency and effectiveness. Job Corps currently has no funding set aside for this purpose. Establishing annual funding for research and development initiatives would enable our program to devote resources toward several emerging program priorities.

Alcohol and drug abuse programs need to be expanded to combat the growing wave of entering youth that need qualified help to battle drug and alcohol dependency. Residential child care programs are needed to increase female enrollment and to give young, single parents a chance to improve their lives.

The Job Corps II programs created in 1986 should be further developed to test the innovative practices, achieve cost efficiencies, and expand the scope of Job Corps services and activities.

Mr. Chairman, my last point is perhaps the most critical and certainly the most immediate. Job Corps faces a crisis that will be dropped on each of our 106 Job Corps centers as soon as July 1 of this year. The Department of Labor has stated that there is a $24 million shortfall in its Job Corps operations account for 1989. Job Corps cannot absorb these unforeseen additional costs.

Costs for operating centers are based on fixed numbers of slots. When prices for services and supplies go up, Job Corps has to pay the difference, or be forced to reduce training slots.

A program year 1989 $24 million shortfall would be disastrous. If something is not done to remedy the situation, Job Corps will cut many services and available slots for new enrollees.

The Department of Labor estimates that approximately 1,400 slots would be eliminated to overcome the deficit. This translates into reducing Job Corps by more than 2,000 enrollees in 1989. The effects of the shortfall would be disastrous.

Mr. Chairman, decisive measures are needed if Job Corps is to avoid a reduction in services and training. We respectfully request that your committee take the necessary steps to resolve this operation shortfall Congress never intended for Job Corps.

It has clearly been the Congress that has worked so hard to expand this program, not diminish it in any way. We come to you today to ask for resources to carry on. Job Corps is a program which has proven it will pay dividends on the investments that we make today.

PREPARED STATEMENT

I speak to you as a center director, as a representative of the Job Corps community, and as someone who has seen first hand the results of a program which deserves our best.

Thank you.

[The statement follows:]

STATEMENT OF DAVID MARANVILLE

I am pleased to appear before you today to present this statement on behalf of the Job Corps community of business, labor and national volunteer organizations. A complete list of these organizations is included with my statement. I have also attached a detailed account of our program goals for Fiscal Year 1990. My name is David Maranville and I am the Center Director of the Denison Job Corps center.

Mr. Chairman, the Job Corps community sincerely appreciates this opportunity to appear before you today and submit facts concerning funding needs for the Job Corps program in Fiscal Year 1990. Due to the tremendous leadership of this subcommittee, Job Corps received funds last year to open 6 new Job Corps centers. When you visit Job Corps centers and actually see the young people striving to improve their lives, you can truly appreciate what your support means. Thanks to your actions last year, Job Corps can more ably reach thousands of needy youth. It is a privilege to be here today and publicly express the gratitude of the Job Corps community for your magnanimous vote of confidence.

As Job Corps celebrates its 25th anniversary throughout 1989, it is appropriate to review what has helped this program survive for 25 years. As you know, an objective, longitudinal 1982 study found Job Corps returns $1.46 to the government for every $1.00 spent on the program - thus serving as a budget deficit reduction tool. In addition, the Job Corps placement rate in 1987 rose to 84%. This rate was achieved with enrollees who, on the average, are economically-disadvantaged 18 year old high school drop-outs, reading at or below a 6th grade level. The Job Corps 25th anniversary slogan states that Job Corps provides "a chance for change." Over 1.4 million youths served since 1964 have found this to be true.

Mr. Chairman, at first glance, things may seem rosy for Job Corps. Unfortunately, that is not the case. There are three items I want to detail for you today. I will discuss the Administration's FY '90 budget request as it pertains to Job Corps, the Job Corps community's program goals for FY 1990, and a pending PY 1989 $24 million operations shortfall.

Mr. Chairman, although the Administration's budget recognizes Job Corps as a vital force in the education and training of this country's youth, it does not adequately confront the realities of operating this national program. The Administration budget request proposes a funding level of $761 million for Job Corps in FY 1990 - an increase of approximately $20 million from last year. According to DOL, this amount will be enough to maintain current Job Corps operations. This, however, is not the whole picture. In fact, what appears to be a modest increase for Job Corps is an inadequate amount. The Administration's figure is based upon faulty assumptions. Thus, OMB's proposal of $761 million will be sufficient only if its questionable assumptions hold true:

- *Inflation for Program Year 1990 is held to 3.4%. - The Congressional Budget Office estimates inflation in 1990 will approach 4.2%. A projection of 3.4% is inadequate and could prove costly to Job Corps. A case in point - this year, Job Corps faces a $24 million shortfall because DOL limited its inflationary projection to just 2%.*
- *The proportion of allowable non-residential slots is increased from 10% to 20%.* - **DOL plans to exchange 4,000 residential slots for 4,000 less costly non-residential slots.** *This assumption strikes at the heart of what makes Job Corps different from other employment and training programs. Ninety percent of Job Corps is residential. The centers take youths out of*

an environment that is often filled with hostility, family [illegible], and drug abuse, and places them in a highly-disciplined living environment. I can tell you as a Center Director that reducing the percentage of center residents by closing dormitories and other center facilities makes no sense and would cause tremendous upset at centers around the nation.

- The thirty Job Corps Civilian Conservation Corps centers are competitively bid out over the next three years. Congressional action will be required to make this change.
- Six hundred Job Corps II slots are eliminated or kept in place at the expense of eliminating equal numbers of slots at existing centers. - Job Corps initiated the Job Corps II programs with the intent to increase effectiveness in management, teaching, counseling, and training on Job Corps centers. In addition, "satellite" programs were implemented to help Job Corps serve greater numbers of disadvantaged youth. Over four years of effort have gone into these programs, many of which are just beginning to come to fruition. It would be a complete waste of time, effort, and money to reduce these programs now - not to mention the fact that it would again relegate Job Corps to serving fewer numbers of youth.
- An accrual of monetary savings from the Job Corps II programs is realized. - As you just heard, many of the Job Corps programs are just beginning to show the results of their efforts. OMB is basing its projections upon savings these programs have generated - but little information is yet available pertaining to Job Corps II savings. To make assumptions based upon these savings would be premature and could later prove costly to Job Corps if they are not accurate.

As you can see, the assumptions made by the Administration do not hold up under close scrutiny. The Job Corps community believes that although a few of these assumptions may result in short-term savings, they are not positive steps and will prove highly-detrimental in the long run for Job Corps.

Job Corps, however, does have significant program needs that we hope will be considered in your deliberations this year. We have pooled our collective experience and are proposing three program goals for Fiscal Year 1990. We seek your help in making those goals a reality.

1. **Continue services to corpsmembers at existing centers (40,544 slots) without closing dormitories to eliminate residential slots.** According to recent statistics from the census bureau, there are now over six million at-risk youths in the U.S. - Many of them unskilled minorities. One out of every four first-graders now lives below the poverty level in the U.S. This increase in disadvantaged youth attempting to enter the labor force in a few years is a demographic reality. Yet annually, Job Corps serves about 100,000 of these youths. It would be harmful to reduce a program which has proven to be one of the best ways to provide america's neediest youth with education, training and residential living. The Administration budget proposal assumes $12 million in savings by closing dormitories ($8 million) and unspecified Job Corps II efficiencies ($4 million). Discounting these unrealistic assumptions, we estimate approximately $770.4 million will be needed to maintain operations at current levels in FY 1990.

2. **Continue to relocate centers that are in facilities no longer conducive to learning.** *It takes a special environment to educate and train the type of youth that is enrolled in Job Corps. When Job Corps centers are opened, they are often located on properties with buildings that have been converted from their original use. Several centers across America are located in facilities that were originally built for purposes other than education. Some centers are also located in older structures that are no longer adequate for residential living. Among the centers affected are the Grafton, Detroit, Cincinnati, Charleston, and Atlanta centers. These centers desperately need to be relocated to facilities more suited to educating and training at-risk youth. An appropriation of $15 million dollars in Fiscal Year 1990 is required to continue the process of relocating centers in need of more appropriate facilities. The Administration's budget proposal provides no funds for this initiative.*

3. **Provide targeted funding to establish and maintain research and development initiatives to improve program efficiency and effectiveness.** *Programs the size of Job Corps are generally able to devote funds for ongoing research and development initiatives in order to improve efficiency and initiate innovative practices. In the business world, this is a necessity. It is no secret to anyone here that organizations which keep pace with changing times are the ones that survive and grow. Job Corps currently has no funding set aside for this purpose. Establishing annual funding for research and development initiatives, would enable Job Corps to devote resources towards several emerging program priorities:*
   - *Alcohol and drug abuse programs need to be expanded to combat the growing wave of entering youth that need qualified help to battle drug-dependency.*
   - *Residential child care programs are needed to increase female enrollment and to give young single parents the chance to improve their lives.*
   - *Finally, the Job Corps II programs created in 1986 should be further developed to test innovative practices, achieve cost efficiencies and expand the scope of Job Corps services and activities.*

With funding to continue the initiation and development of these, Job Corps could clearly improve the services it provides for young people.

Mr. Chairman, my last point is perhaps the most crucial and most immediate. Job Corps faces a crisis that will be felt on each of its 106 centers as soon as July 1st of this year. **The DOL has stated there is a $24 million shortfall in its Job Corps operations account for 1989.**

Several factors have contributed to this shortfall:

- *Estimated increases for inflation were based upon 2% when the actual inflationary rate was actually closer to 3.8%.;*
- *Staff salary adjustments were needed to reach competitive levels in the local labor markets and these ran higher than earlier estimates; and*
- *Job Corps received a 1.2% across the board cut applied to the 1989 funding level.*

Job Corps can not absorb these unforeseen additional costs. Costs for operating Job Corps centers are based on fixed number of slots. When prices for services and supplies go up, Job Corps has to pay the difference - or be forced to reduce training slots.

A Program Year 1989 $24 million shortfall will be disastrous. If something is not done to remedy the situation, Job Corps will cut many services and available slots for new enrollees. **The Department of Labor estimates that approximately 1,400 slots would be eliminated to overcome the deficit. This translates into reducing Job Corps by more than 2,000 enrollees in 1989.** *The effects of the shortfall will be felt in July - less than two months from today.*

DOL is proposing to transfer $13.5 million into the operations account from its capital account to help overcome the shortfall. This means using funds appropriated by Congress last year for six new Job Corps centers. Completing the last two centers would be delayed - perhaps permanently. Transferring $13.5 million also barely covers half of the shortfall. DOL has not yet stated how it intends to account for the remaining $10.5 million shortfall.

Mr. Chairman, the Job Corps community is in agreement. **Decisive measures are needed if Job Corps is to avoid a reduction in services and training slots this year.** *We respectfully request that your committee take the necessary steps to resolve this operations shortfall Congress never intended for Job Corps. In fact, it has clearly been the Congress that has worked so hard to expand this program, not diminish it in any way.*

Mr. Chairman, we come to you today to ask you for the resources to carry on. Once again your committee has the unenviable job of funding hundreds of programs while trying to reduce a federal budget deficit. It will not be easy. Job Corps is a program which has proven it will pay dividends on the investments we make today. You have seen the evidence that this is true. I speak to you as a Center Director, as a representative of the Job Corps community, and as someone who has seen firsthand the results of a program which deserves our best. Thank you.

JOB CORPS' GOALS

FOR 1990

Background

Job Corps is unique among all government programs in the United States. It is the only residential education and training program that exists solely to serve hard-core, unemployed, undereducated youth. Now celebrating its 25th year of operation, Job Corps has successfully educated, trained and placed over 1.3 million at-risk youth into productive employment, the military and further education.

Administration's FY '90 Job Corps Funding Request

The Administration has requested a total of $761.6 million for Job Corps in Fiscal Year 1990. This funding level will maintain existing Job Corps centers at their combined enrollment capacity of 40,544 full-time training positions if the following conditions are met:

- *The proportion of allowable non-residential slots is increased from 10% to 20%. The increase would eliminate 4,000 existing residential slots (e.g., closing dormitories) in favor of 4,000 less-costly non-residential slots. (DOL estimated savings - $8 million).*
- *Contracting out for the operation of ten of the thirty Civilian Conservation Centers. Another ten would follow in 1991 and the final ten in 1992. DOL indicates that savings would accrue in the out years but that the one time federal severance costs would actually exceed any savings in 1990 by about $2 million.*
- *The 600 additional Job Corps II pilot program training slots are eliminated or are kept in place at the expense of eliminating an equal number of slots at existing centers.*
- *Prospective savings from the Job Corps II program pilot and demonstration efforts actually materialize. The Administration asserts that Job Corps II programs will yield approximately $4.3 million in annual savings. Little information has been provided regarding whether these savings have been achieved.*
- *Inflationary increases are limited to 3.4% above 1989 prices.*

Job Corps Goals for 1990

There are three major program goals for Job Corps in 1990:

Goal 1. **Maintain the current levels of operations at existing centers (40,544 slots) without closing dormitories to eliminate residential slots or contracting out Civilian Conservation Corps centers.**

Annually, Job Corps provides over 100,000 of America's at-risk youth with an opportunity for education, training and residential living. Intensive congressional scrutiny and objective longitudinal studies have shown Job Corps to return $1.46 for each dollar invested in the program - producing benefits far in excess of costs.

The Administration's 1990 budget request would accomplish this objective, but only if:

1) *dormitories were closed to eliminate 4,000 .residential slots and replace these with 4,000 non-residential slots; and*

2) *10 Civilian Conservation Corps centers go through a competitive bid process. While Job Corps could provide needed services to additional non-residential enrollees, it makes no sense to close dormitories since the need for residential services has not declined. The Civilian Conservation centers serve a very specific purpose, integral to the objectives of Job Corps. As the July, 1986 GAO report found, youth trained at Civilian Conservation Centers are highly employable, receive excellent starting wages and are highly involved in public service activities. Closing centers or bidding out Civilian Conservation Centers to other entities would be highly disruptive and counterproductive.*

Goal 2. **Begin relocating centers that are in delapidated facilities.**

A handful of Job Corps centers need to be relocated.

Their programs operate in facilities that do not provide an environment conducive to learning. The affected centers include: Grafton, Detroit, Cincinnati, Charleston, Atlanta.

The Administration's budget request does not provide funds for any center relocations. While costs for accomplishing all relocations in one year may be prohibitive ($44.2 million), it is imprtant to start the process. A sum of $15 million would permit two relocations in Program Year 1990.

Goal 3. **Provide targeted Job Corps funding to establish and maintain research and development initiatives to improve program efficiency and effectiveness.**

Programs of Job Corps' size generally devote a set amount of funds to ongoing research and development activities. Establishment of funding for research and development initiatives in Job Corps would assure the existence of a more cost-efficient and programmatically sound national Job Corps over the next decade. Several priorities have emerged:

A. **Establishing residential child care services on Job Corps centers;**

B. **Maintaining successful Job Corps II pilot and demonstration projects without decreasing slots at existing centers;**

C. **Providing funds to develop and expand Job Corps alcohol and drug abuse treatment programs.**

The Administration's budget request includes no funds for research and development initiatives.

JOB CORPS
1990
FUNDING REQUEST

			Funding Needed to Accomplish Objectives ($ in millions)
Needed			*Administration Request*
1.	*Maintain all established Job Corps centers and provide for repairs*	*$760.1**	*$770.4*
2.	*Address Special Capital Needs:*		
	Relocation of centers	---	*$ 15.0*
3.	*Research and Development Initiatives:*	---	
	a. Residential Child Care	*$ 1.5*	*$ 3.0*
	b. Maintain 600 Job Corps II slots	---	*$ 10.8*
	c. Expand Alcohol and Drug Abuse Programs	---	*$ 4.0*
	TOTAL	*$761.6*	*$803.2*

* *Includes initiative to eliminate 4,000 residential slots (save $71.8 million) and establish 4,000 non-res slots (at a cost of $63.8 million).*

Organizations Committed to Job Corps

Home Builders Institute, the Educational Arm of the National Association of Home Builders
National Association of Home Builders Auxiliary
General Electric Government Services
Career Systems Development Corporation
Teledyne
ITT
Management and Training Corporation
Coyne American Institute
Texas Educational Foundation
Res-Care, Inc.
Training and Management Resources
YWCA of Los Angeles
Women in Community Service
MINACT, Inc.
Joint Action in Community Service
Vinnell Corporation
Grand Rapids Public Schools
Tuskegee University
Training and Development Corporation
Wackenhut Services, Inc.
Leo A. Daly
Alpha Kappa Alpha Sorority, Inc.
Commonwealth of Puerto Rico
Cherokee Nation of Oklahoma
University of Nevada-Reno
Pacific Education Foundation
Puerto Rico Volunteer Youth Corps
AFL-CIO International Brotherhood of Painters and Allied Trades
AFI-CIO International Union of Operating Engineers
AFL-CIO Appalachian Council
AFL-CIO United Auto Workers
United Brotherhood of Carpenters and Joiners
U.S. Department of Agriculture - Forest Service
U.S. Department of Interior - Bureau of Reclamation
U.S. Department of Interior - Fish and Wildlife
U.S. Department of Interior - National Park Service
National Maritime Union - Treasure Island Job Corps
International Masonry Institute
National Plastering Industry's Joint Apprenticeship Trust Fund
Transportation - Communications International Union
Tribal Council of the Confederated Salish and Kootenai Tribes of the Flathead Indian Reservation

Senator **Inouye**. I can assure you that Congress will not only study, but do something about, the shortfall.

I would like to get your views on the $5 million earmark requested by OMB to evaluate the Job Corps. Are you for or against it?

Mr. **Maranville**. Mr. Chairman, it would take $5 million just to hire staff to review the studies that have been done on Job Corps every year for the past 5 years. I do not know what they are going to study.

I can take that $5 million and put a significant number of young women with children in the solo parent program in Job Corps centers. I do not know what they are going to study. Obviously, I am against it.

We are not afraid of the study. We are not afraid of continuing to demonstrate and be held accountable for the operation of our program.

Senator **Inouye**. You think it is just a waste of money?

Mr. **Maranville**. Yes, sir.

Senator **Inouye**. I thank you very much, sir.

STATEMENT OF JAMES A. HUBBARD, DIRECTOR, NATIONAL ECONOMICS COMMISSION, AMERICAN LEGION

Senator **Inouye**. Our next witness is the director of the National Economics Commission of the American Legion, James A. Hubbard.

Mr. Hubbard, welcome, sir.

Mr. **Hubbard**. Thank you, Mr. Chairman.

This morning has been a real education for me, listening to the witnesses from your State.

I would hope that this subcommittee and the whole committee take advantage of what they said, in order that Hawaii remains the paradise that I so fondly remember from my three visits.

Now, on to veterans.

In spite of low unemployment rates nationwide, thousands of veterans are still experiencing problems with unemployment and underemployment. The Secretary of Labor's committee on veterans' employment concludes that 35 percent or about 165,000 of all homeless males are veterans.

Some 54 percent of the homeless veteran population are nonwhite, and 51 percent of this population are in the prime labor force group.

The Bureau of Labor Statistics estimates that a disproportionate number of dislocated workers are veterans.

Mr. Chairman, title IV–C of the Job Training Partnership Act pertains to job training for veterans. In light of this data that I just cited, we believe it is appropriate to reallocate money from other portions of JTPA to serve these deserving people.

That is funded at $400 million, and since nearly 25 percent of dislocated workers are veterans, does it not make sense to use about 25 percent of those funds to assist that portion of the dislocated worker population who are veterans?

We would also argue that since 35 percent of homeless males are veterans, it seems reasonable to use 35 percent of funds set aside for homeless and target them at homeless veterans.

In any case, title IV–C is seriously underfunded. Funding for the disabled veterans' outreach program and for the local veterans' employment representative program are adequate, we believe, this year.

We will be working with the oversight committees and with Congress to ensure that funds for both of these programs are properly administered by the Department and properly utilized by the States.

One area of major concern is that nearly two-thirds of those veterans who are 60 percent or more disabled are not in the labor force. The Department has promised results in this area, and we will hold them to it. In fact, the Department has promised to focus its efforts in reducing the duration of unemployment for recently separated veterans, and attacking the structural unemployment problems of disabled combat theatre Vietnam-era veterans.

Once again, we will be pleased to work with the oversight committees and the Department to see that progress is made in these areas.

The National Veterans' Training Institute is targeted for funding at $2.6 million this year. We urge favorable consideration from this committee. Funds requested are at the same level as last year, and while we realize that this amounts to doing more with less, because of the effects of inflation, we are prepared to monitor the situation for 1 year in light of the budget deficit, which seems to be getting a lot of attention.

PREPARED STATEMENT

In general, Mr. Chairman, we are pleased with the request for veterans this year for the Department of Labor budget. We would urge this subcommittee to support the request.

It has been my honor to appear before you, one of America's most distinguished veterans, this morning, Mr. Chairman. I thank you very much for this opportunity.

[The statement follows:]

STATEMENT OF JAMES A. HUBBARD

Thank you, Mr. Chairman, for providing this opportunity to offer our views on funding for the important work carried out by the Veterans Employment and Training Service in the Department of Labor. In spite of the low unemployment rate nationwide, thousands of veterans are still experiencing problems with unemployment and underemployment. The American Legion is particularly concerned with the growing number of dislocated workers and the homeless that are veterans which still need the help of this subcommittee.

The Secretary of Labor's Committee on Veterans Employment concludes that 35 percent, or about 165,000, of all homeless males are veterans; 54 percent of the homeless veteran population are nonwhite; and 51 percent of the homeless veteran population are in the prime labor force age group. Studies done in some cities show that up to 40 percent of the homeless population are veterans. Similarly, the Bureau of Labor Statistics estimates that a disproportionate number of dislocated workers are veterans. Whereas veterans make up about 15 percent of the labor force, from nearly 25 percent of dislocated workers are veterans. Clearly there is much work to be done in this area.

Mr. Chairman, Title IV (c) of the Job Training Partnership Act pertains to job training for veterans. In light of the data just cited we believe it appropriate to reallocate money from other portions of JTPA to serve these deserving people. The portion of JTPA dealing with dislocated workers is funded at $287 million. Since nearly 25 percent of dislocated workers are veterans, does it not make sense to use approximately 25 percent of these funds to assist that portion of the dislocated worker population who are veterans? Similarly, we would also argue that since 35 percent of homeless males are veterans, it seems reasonable to reallocate 35 percent of those funds requested for homeless programs and target them at homeless male veterans. We would urge serious consideration of these proposals. Title IV (c) of JTPA is seriously underfunded.

Funding for the Disabled Veterans Outreach Program (DVOP) for FY 1990 is requested at $75.167 million. This is intended to provide grant funds for 1,861 DVOP positions in accordance with Title 38. The Local Veterans Employment Representative Program (LVER) is funded at $69.250 million to cover 1,600 positions.

The American Legion will be working with the oversight committees to insure that funds for both of these programs are properly administered by the Department and properly utilized by the states. Of particular interest will be promised emphasis on economically and educationally disadvantaged veterans, and those veterans who are 60 percent or more disabled. Nearly 66 percent of these disabled veterans are not in the labor force. The Department has promised results in these areas, and we will hold them to it.

Public Law 100-323 mandates that the Department maintain a Regional Administrator for the Veterans Employment and Training Service in each Federal Region where the Secretary of Labor has a Regional Office. The funding request contains 15.606 million to carry out this mandate. We are pleased that the Assistant Secretary has recently filled these positions. We urge this committee to approve the funding request in order that the positions can be maintained. The Department has promised to " focus its efforts on reducing the duration of unemployment for recently separated veterans, and attacking the structural unemployment problems of disabled combat theater Vietnam-era veterans." Once again, we will work with the Department and with the oversight committees to see that progress is made in these areas.

The National Veterans Training Institute (NVTI) funding is targeted at a level of $2.6 million. This is another program mandated by P.L.. 100-323, and is intended to provide training to Federal and State Staff. The funding will provide training to about 2,500 people in FY 1990. We urge favorable consideration from this committee. We recognize that the funds requested are at the same level as last year. While we realize that this amounts to doing more with less due to inflation, we are prepared to monitor the situation for one year in light of the budget deficit which seems to be getting a lot of attention.

In general Mr. Chairman, we are pleased with the budget request for veterans programs at the Department of Labor for FY 1990. We would urge this subcommittee to support the request in order to carry out the mandates of P.L. 100-323, which will help those veterans who most need the assistance of a sympathetic government.

Thank you for the opportunity to appear today.

Senator **Inouye**. Thank you very much, Mr. Hubbard. You are very kind.

I was interested in one set of statistics you just gave us. Two-thirds of those 60 percent disabled or more are not in the labor market?

Mr. **Hubbard**. That is correct, sir.

Senator **Inouye**. Do you have any reasons for this?

Mr. **Hubbard**. I think some of them have given up. I suspect that employers are reluctant to hire disabled people because they do not know exactly what they are able to do, or what they are able not to do. In fact, disabled people can be some of the most productive workers that our society has in its labor force. There has probably been a bit of shortfall in the efforts of the disabled veterans outreach program specialists to reach out to these people, to locate them, and to get them back into the labor force.

For all of the above reasons, I think that that statistic holds.

Senator **Inouye**. I was under the impression that the effort we have made to employ the handicapped has been working—but this is a terrible number. Two-thirds?

Mr. **Hubbard**. That is correct. It is two-thirds.

Now, I am speaking of veterans. I am not speaking of handicapped in general.

Senator **Inouye**. I do not think this will be the same statistics you would find in the general public.

Mr. **Hubbard**. That is entirely possible, and that is our point: That veterans are existing—not living, but existing—on the margins of our society at this point.

While the overall veterans' employment rate is better than the employment rate of the labor force, or the population in general, those veterans on the margin are much, much worse than the others on the margins of our society.

Those are the people that we advocate targeting.

Senator **Inouye**. Well, I thank you very much, Mr. Hubbard.

I can assure you that this committee, as in the past, will be listening to your views very carefully.

Mr. **Hubbard**. Thank you, Mr. Chairman.

STATEMENT OF MERLE WILSON, AMERICAN ASSOCIATION OF RETIRED PERSONS

Senator **Inouye**. Our next witness is Merle Wilson, of the American Association of Retired Persons.

Mr. **Wilson**. Thank you, Senator.

On behalf of the American Association of Retired Persons, thank you for this opportunity to speak on the 1990 funding for programs under the subcommittee's jurisdiction.

My name is Merle Wilson. I am associate area vice president for AARP in region VI.

Due to constraints of time, I will highlight only three of the association's priorities. Others will be found in the written statement.

First——

Senator **Inouye**. Mr. Wilson, may I interrupt?

Mr. **Wilson**. Yes.

Senator **Inouye**. I just got notified that I have 5 minutes left to vote. I will be right back, sir.

Mr. WILSON. Fine. Thank you.

[A brief recess was taken.]

Mr. WILSON. Thank you, Senator.

You have a tough job, and we appreciate all the work that you do.

Senator INOUYE. This is the least I can do.

Mr. WILSON. I mentioned that I would be stressing three highlights of priorities.

The first one is that the association supports the restoration of funding for the low-income home energy assistance program to $1.6 billion, recognizing that the budget constraints make necessarily even this funding level difficult to achieve.

We strongly urge that some significant restoration be made. About $1 billion will have been cut from the program since 1985, if the current administration proposal is adopted.

Already fewer than one-third of the eligible low-income households actually are served.

LIHEAP is crucial to the low-income Americans who are most susceptible to heat stroke and hypothermia, and are, therefore, given priority for services. LIHEAP pays only a portion of the household energy bill, but this can make a difference between illness and health, to say nothing of the comfort that you spoke about earlier.

Contrary to popular opinion, some 66 percent of the LIHEAP households do not receive any public assistance, but are working. They are the working poor or the elderly.

Second, the association recommends that funding for Older American Act programs administered by the Department of Health and Human Service be continued at no less than the fiscal year 1989 level, with an addition of $10 million for outreach demonstrations in SSI, Medicaid, and food stamps.

Third, we urge significant fiscal year 1990 funding to maintain at a minimum the Older Americans Act, title V, senior community service employment program, SCSEP, at present enrollment of 65,804 authorized permanent positions.

If a minimum wage increase becomes effective during the fiscal year 1989-90 program year, AARP urges the subcommittee to approve a supplemental appropriation to assure that no current low-income title V enrollee will lose his or her job.

PREPARED STATEMENT

Mr. Chairman, you will find AARP recommendations regarding funding for Medicare contracts, nursing home inspections, geriatric training, and National Institutes of Health in the written statement.

I thank you for this opportunity to meet before you, and hope that the subcommittee carefully considers AARP Association recommendations.

Thank you.

[The statement follows:]

STATEMENT OF MERLE WILSON

ON BEHALF OF THE AMERICAN ASSOCIATION OF RETIRED PERSONS (AARP), THANK YOU FOR THIS OPPORTUNITY TO TESTIFY CONCERNING FY 1990 FUNDING FOR PROGRAMS UNDER THIS SUBCOMMITTEE'S JURISDICTION. MY NAME IS MERLE WILSON, AND I AM FORMER CHAIRMAN OF THE AARP IOWA STATE LEGISLATIVE COMMITTEE, AND CURRENT ASSOCIATE AREA VICE PRESIDENT FOR AARP REGION VI.

AARP'S RECOMMENDATIONS CAN BE SUMMARIZED AS FOLLOWS:

1) PROVIDE A SIGNIFICANT RESTORATION OF FUNDS ($1.6 BILLION) TO THE LOW INCOME HOME ENERGY ASSISTANCE PROGRAM (LIHEAP); ENSURE, AT A MINIMUM, CURRENT SERVICES FUNDING.

2) PROVIDE NO LESS THAN FY 1989 FUNDING FOR OLDER AMERICANS ACT (OAA) PROGRAMS ADMINISTERED THROUGH THE ADMINISTRATION ON AGING ($724.7 MILLION), PLUS $10 MILLION FOR THE SSI, MEDICAID, AND FOOD STAMP OUTREACH DEMONSTRATIONS AUTHORIZED IN THE 1987 AMENDMENTS.

3) RAISE THE FY 1990 APPROPRIATION FOR THE SENIOR COMMUNITY SERVICE PROGRAM (SCSEP, TITLE V OF THE OAA) BY AN AMOUNT ADEQUATE TO ACCOMMODATE MINIMUM WAGE INCREASES AT CURRENT SERVICES LEVEL.

4) INCREASE FUNDING FOR MEDICARE STATE NURSING HOME CERTIFICATION PROGRAM TO ALLOW FOR NEW MANDATED RESPONSIBILITIES.

5) PROVIDE SUFFICIENT FUNDING TO MAINTAIN CURRENT SERVICES IN THE GERIATRIC HEALTH CARE TRAINING PROGRAM AND FOR RESEARCH BY THE NATIONAL INSTITUTES OF HEALTH.

A. LOW INCOME HOME ENERGY ASSISTANCE PROGRAM (LIHEAP)

THE ASSOCIATION SUPPORTS RESTORATION OF LIHEAP FUNDING TO $1.6 BILLION. RECOGNIZING THAT BUDGET CONSTRAINTS COULD MAKE EVEN THIS LEVEL OF RESTORATION DIFFICULT, WE STRONGLY URGE THAT SOME SIGNIFICANT RESTORATION BE MADE, GIVEN A SUCCESSION OF FEDERAL CUTS IN THE PROGRAM OVER RECENT YEARS. ASSUMPTIONS THAT CUTS IN FEDERAL APPROPRIATIONS WOULD BE RESTORED THROUGH OTHER FUNDING SOURCES AVAILABLE TO THE STATES HAVE NOT BEEN REFLECTED IN STATE ALLOCATION DECISIONS. CUMULATIVELY, ABOUT $1 BILLION WILL HAVE BEEN CUT FROM THE PROGRAM SINCE FY 1985 IF THE CURRENT

ADMINISTRATION PROPOSAL IS ADOPTED, DESPITE THE FACT THAT FEWER THAN 1/3 OF ELIGIBLE LOW INCOME HOUSEHOLDS ACTUALLY GET SERVED.

LIHEAP IS CRITICAL TO LOW INCOME OLDER AMERICANS, WHO ARE MOST VULNERABLE TO HEAT STROKE AND HYPOTHERMIA AND ARE THEREFORE GIVEN PRIORITY FOR SERVICE. OF THE LOW INCOME HOUSEHOLDS RECEIVING WINTER HEATING AND SUMMER COOLING ASSISTANCE, 38 PERCENT AND 56 PERCENT, RESPECTIVELY, HAVE HAD AT LEAST ONE OLDER OCCUPANT. LIHEAP PAYS ONLY A PORTION OF THE ENERGY BILL FOR LOW INCOME HOUSEHOLDS, BUT THIS ASSISTANCE CAN MAKE THE DIFFERENCE BETWEEN ILLNESS AND HEALTH -- NEVER MIND BASIC COMFORT.

WHILE ENERGY PRICES ARE NOT RISING AS RAPIDLY AS IN THE EARLY 1980'S, NEITHER ARE THE BUDGETS OF LIHEAP-ELIGIBLE HOUSEHOLDS. THE PROPOSED CUT OF ALMOST $300 MILLION COULD MEAN ELIMINATING OVER ONE MILLION LOW INCOME HOUSEHOLDS AND REDUCING BENEFITS TO SEVERAL MILLION POOR FAMILIES. AND, CONTRARY TO POPULAR OPINION, 66% OF LIHEAP HOUSEHOLDS DO NOT RECEIVE ANY FORM OF PUBLIC ASSISTANCE, BUT ARE PART OF THE LARGE UNDERCLASS KNOWN AS THE WORKING POOR.

WHILE MANY STATES USE PORTIONS OF THEIR OIL OVERCHARGE ALLOCATION FOR LIHEAP, THE TOTAL OIL OVERCHARGE MONIES SPENT ON LIHEAP HAVE NOT BEEN SUFFICIENT TO OFFSET THE TOTAL REDUCTION FROM THE FEDERAL PROGRAM. AARP DOES NOT OPPOSE OTHER USES OF OIL OVERCHARGE FUNDS BY THE STATES; WE SIMPLY POINT OUT THAT IT IS NOT APPROPRIATE TO ASSUME THAT STATES EITHER PLAN TO, DESIRE TO, OR WILL BE PERMITTED TO COMPLETELY RESTORE FEDERAL LIHEAP CUTS. EVEN IF THE STATES WANTED TO USE ALL OF THEIR OIL OVERCHARGE FUNDS ON LIHEAP, DOE ADMINISTRATIVE GUIDELINES ON PERMISSIBLE USES OF FUNDS WOULD PRECLUDE THAT OPTION. THEREFORE, ENERGY ASSISTANCE MUST COMPETE WITH SUCH POPULAR PRESCRIBED AND ELIGIBLE USES AS HIGHWAY CONSTRUCTION, AIRPORTS, AND BIKE PATHS. MEANWHILE, ELDERLY AND WORKING POOR HOUSEHOLDS SUFFER THE CONSEQUENCES.

B. OLDER AMERICANS ACT/ADMINISTRATION ON AGING

THE ASSOCIATION RECOMMENDS THAT FUNDING FOR OLDER AMERICANS ACT PROGRAMS ADMINISTERED BY THE DEPARTMENT OF HEALTH AND HUMAN

SERVICES BE CONTINUED AT NO LESS THAN FISCAL YEAR 1989 LEVELS, WITH AN ADDITIONAL $10 MILLION FOR OUTREACH DEMONSTRATIONS IN SSI, MEDICAID, AND FOOD STAMPS.

TODAY, MANY AGED PERSONS ARE ABLE TO LIVE INDEPENDENTLY IN THEIR OWN HOMES BECAUSE OF EFFECTIVE AND INNOVATIVE SUPPORTIVE SERVICES, MEALS, PROGRAMS, TRAINING, RESEARCH AND DEMONSTRATION PROVIDED BY THE ACT. AARP AND OTHER AGING ORGANIZATIONS HAVE DEMONSTRATED THAT OUTREACH CAN INCREASE PARTICIPATION IN SSI. A NATIONAL DEMONSTRATION REPLICATING SUCCESSFUL OUTREACH MODELS SUCH AS THESE COULD HELP LOW INCOME PERSONS ACROSS THE COUNTRY.

C. TITLE V SENIOR COMMUNITY SERVICE EMPLOYMENT PROGRAM

THE ASSOCIATION URGES THE SUBCOMMITTEE TO APPROVE SUFFICIENT FUNDING TO MAINTAIN, AT A MINIMUM, THE OLDER AMERICANS ACT TITLE V SENIOR COMMUNITY SERVICE EMPLOYMENT PROGRAM (SCSEP) AT ITS PRESENT ENROLLMENT -- 65,804 AUTHORIZED PERMANENT POSITIONS.

AN INCREASE IN THE FEDERAL HOURLY MINIMUM WAGE SEEMS LIKELY TO BE ENACTED DURING THIS CONGRESS. IF AN INCREASE AT THE LEVEL RECENTLY APPROVED BY THE HOUSE AND SENATE IS ENACTED FOR THE FY 1990-91 SCSEP PROGRAM YEAR, A FUNDING LEVEL OF APPROXIMATELY $398 MILLION WOULD BE NEEDED TO MAINTAIN CURRENT ENROLLMENT. IF THE ADMINISTRATION PROPOSAL FOR A SMALLER WAGE INCREASE IS ENACTED, OBVIOUSLY A SMALLER INCREMENT IN FUNDING WILL BE NEEDED TO KEEP THE PROGRAM WHOLE (ABOUT $368 MILLION, BASED ON CURRENT ASSUMPTIONS) .

AARP FURTHER URGES THAT IF A MINIMUM WAGE INCREASE BECOMES EFFECTIVE DURING THE FY 1989-90 PROGRAM YEAR, THE SUBCOMMITTEE APPROVE A SUPPLEMENTAL APPROPRIATION TO MAINTAIN CURRENT ENROLLMENT AND ASSURE THAT NO LOW-INCOME TITLE V ENROLLEE WILL LOSE HIS OR HER JOB.

D. MEDICARE CONTRACTOR FUNDING

AARP URGES THE SUBCOMMITTEE TO PROVIDE A REALISTIC LEVEL OF FUNDING FOR MEDICARE CONTRACTORS IN FISCAL YEAR 1990. CONTRACTORS ARE RESPONSIBLE FOR REIMBURSING MEDICARE

BENEFICIARIES AND PROVIDERS, AND PROVIDE TECHNICAL ASSISTANCE AND INFORMATION ABOUT CHANGES IN THE MEDICARE PROGRAM. WITHOUT REASONABLE FUNDING, WE CAN EXPECT FURTHER DELAYS AND ERRORS IN PROCESSING PAYMENTS FOR BENEFICIARIES AND PHYSICIANS.

E. NURSING HOME INSPECTIONS

AARP SUPPORTS INCREASED FUNDING FOR THE MEDICARE STATE NURSING HOME CERTIFICATION PROGRAM TO MEET NEW DEMANDS OF THE NURSING HOME QUALITY ASSURANCE PROVISIONS OF THE 1987 OMNIBUS BUDGET RECONCILIATION ACT. THE STATE CERTIFICATION PROGRAM ENSURES THAT ALL INSTITUTIONS AND AGENCIES WHICH PROVIDE SERVICES TO MEDICARE BENEFICIARIES MEET QUALITY AND SAFETY STANDARDS.

THE ASSOCIATION ALSO OPPOSES CURRENT PROPOSALS TO CUT THE SPECIAL MEDICAID MATCHING RATES FOR FUNCTIONS -- SUCH AS NURSING HOME SURVEY AND CERTIFICATION AND NURSE AIDE TRAINING -- ESTABLISHED BY THE NURSING HOME QUALITY ASSURANCE PROVISIONS. REDUCING THESE SPECIAL MATCHING RATES WOULD SEVERLY DAMACE STATES' ABILITY TO IMPLEMENT THESE PROGRAMS SUCCESSFULLY.

F. GERIATRIC TRAINING

AARP SUPPORTS FUNDING SUFFICIENT TO MAINTAIN CURRENT SERVICES FOR FEDERAL PROGRAMS IN GERIATRIC HEALTH CARE TRAINING. THE RAPIDLY AGING POPULATION AND THE ESTIMATED SHORTAGE IN HEALTH CARE PROFESSIONALS UNDERSCORE THE NEED FOR FEDERAL SUPPORT OF GERIATRIC TRAINING.

G. NATIONAL INSTITUTES OF HEALTH

AARP SUPPORTS CONTINUED FUNDING AT THE CURRENT SERVICES LEVEL FOR RESEARCH CONDUCTED BY THE NATIONAL INSTITUTES OF HEALTH (NIH). THE TWELVE RESEARCH CENTERS WHICH COMPRISE NIH HAVE PLAYED IMPORTANT ROLES IN ADVANCING NOT ONLY AGING RESEARCH, BUT RESEARCH TO BENEFIT ALL GENERATIONS.

AARP APPRECIATES THE SUBCOMMITTEE'S CAREFUL CONSIDERATION OF THESE RECOMMENDATIONS AND STANDS READY TO WORK CLOSELY WITH MEMBERS AND STAFF AS YOU PROCEED TOWARD MARKUP OF A BILL FOR FY 1990.

Senator **Inouye**. Although I have no intentions to retire at this time, as you know I am a dues-paying member of your organization.

As a dues-paying member, I would like to commend you for what you are doing, and as a member, I thank you for your services.

Mr. **Wilson**. Thank you.

If we had a special handshake, I would shake your hand there.

Thank you very much.

Senator **Inouye**. Thank you.

STATEMENT OF DAVID BRADLEY, NATIONAL COMMUNITY ACTION FOUNDATION

Senator **Inouye**. Our next witness is David Bradley, representing the National Community Action Foundation.

Mr. Bradley, welcome, sir.

Mr. **Bradley**. Thank you.

If it is OK, I would like to submit my written testimony for the record.

Senator **Inouye**. Your full statement will be made part of the record.

Mr. **Bradley**. I appreciate that. I promise that I will be very brief.

I come here with some hesitation. I have been watching House and Senate debates on the budget, and the consideration, and I am fully aware of the tight constraints that this committee is going to be facing this year.

So, in starting my discussion with you, it is with full realization that this is going to be a very, very extraordinarily difficult year, perhaps even more so than we envision now.

I am here to talk about the community services block grant, and a little bit about LIHEAP.

The community services block grant, again, for 6 out of the last 9 years, the administration is requesting zero funds for it. It gets a little bit frustrating because there are a lot of good indications that certain individuals within the administration support the program, and certainly the studies that have been done have been very encouraging about the effectiveness of the program.

In 1986, the General Accounting Office took a look at the Reagan administration's concerns about the program—the duplications, and things like that, and they issued, in the words of Senator Hatfield, a report card, and gave the program an A plus.

This year, we are seeing again some of the same arguments come forward, and for instance, Secretary Sullivan has on record, in front of the Budget Committee, requested a zeroing out of the program, and yet last week indicated how important community action agencies are in terms of a partnership with HHS in delivering services to the poor.

There was an article in yesterday's New York Times—front page—about rural homelessness, I read through the article, and certainly it is an element that we hear a lot about. I would point out in my testimony for the committee an August 8, 1988 Newsweek article about the rural poor—their cover story.

In there, it is called America's third world. In there, they talk about how hard and how difficult it is for the rural poor to make it in this country, and I would point out that every agency that they refer to as delivering services, necessary services, are community action agencies.

Even the First Lady, Barbara Bush, last week, said in a letter to me on an issue that she believes community action agencies exemplify what is best in America—our active compassion for others, and reaching out for those in need.

So I come before you with basically five requests—not easy ones, but ones that I have thought about very carefully.

No. 1, if in the next 60 days or so, we can lay out for the committee, as we continue to talk to staff and members, the needs for the community services block grant, in terms of what is going on in your States.

There are five agencies, for instance, in your State receiving $1.4 million in funding. We can lay out those needs. We would urge that the committee take a careful look at the funding for this program. It has been frozen or cut for the last 6 years.

What we have is two issues developing that potentially affect all the members on this subcommittee and in the U.S. Senate. No. 1 is that there are pressures emerging by certain members on the subcommittee to change the formula, because money is that tight in their States.

So we may see a formula fight emerge.

Second, there are also pressures emerging on some other States to do waivers and other programs to try to get money back into the community services block grant. So we have got some funding needs. I think those pressures will be dominant on our program throughout this subcommittee's process.

If I had to recommend a figure, it would be $350 million. Last year's funding was $391 million.

Second, fuel assistance—the LIHEAP program—very important. You have heard excellent testimony today. My sense is that you are going to have a tough time in going above last year's level.

I would hope that the draconian cuts that it has taken in the last few years would be things of the past, and we could look at least a base line freeze on that.

Next is the McKinney Act. President Bush has called for full funding on the McKinney Act. The FEMA report talks about how critical community action agencies are in delivering services to the homeless.

There is, of course, in the McKinney Act, the community action agencies—dedicated to them and use—and both House and Senate budget resolutions prioritize that program, and they indicate that it ought to be fully funded, which would be $42 million.

Finally, the last point is that Congress and the Nation and clearly the President have set a priority for combatting drugs, and this committee and particularly the leadership in this committee has taken a very active role in the last few years in providing money for drug education and drug prevention.

I would hope that if there are States not applying for money, if there is money that is not being spent—I would hope that we could approach the committee in a fairly creative way to tie in community action agencies a little better on some of that.

Certainly no one knows the low-income community like these people—the high-risk community.

So I leave you probably where I began, and that is, Mr. Chairman—you were there on August 20, 1964, when Lyndon Johnson signed the Economic Opportunity Act into law and launched the war on poverty.

PREPARED STATEMENT

There are very few Members in the House and Senate left who were in that photograph that I have hanging in my office, but it did signal a commitment by this Nation and this Government to improving the lives of the poor. I would hope that in your deliberations, you would look at these programs and do the best that you can, knowing the constraints that you face.

I fully appreciate those.

Thank you very much.

[The statement follows:]

STATEMENT OF DAVID BRADLEY

Good morning, I am David Bradley, here today on behalf of the National Community Action Foundation, which is the Washington representative of the nation's 900 Community Action Agencies. Mr. Chairman, I am grateful to be able to testify in front of this Subcommittee.

The Administration has again requested a drastic reduction in the Community Services Block Grant; the first step toward a phase out some time in the future.

As in past years, they have argued that the gap caused by reduced CSBG monies can be filled by other funds such as the Social Services Block Grant, Head Start, Low-Income Energy Programs, Community Development, Job Training, and others.

Mr. Chairman, as the Subcommittee is aware, and I might add, as most communities in America are aware, tremendous funding pressures exist on those programs as well.

o The GAO told us in 1986 that Community Services Block Grant funds are used for unique and non-duplicative purposes.

o CSBG funds are used to initiate new local programs and provide direct services not already available.

o The new draft report on FY1987 CSBG shows that these monies fund the local distribution and coordinate around $3 billion in federal, state, and private funds.

o Without CSBG, there would be no way in most counties to comprehensively assess family needs and assemble a custom-made package to let that family get itself out of poverty.

o One quarter of CSBG funds locally pay for comprehensive case management.

o The FY 1987 draft report shows 20% of CSBG is used to meet the many emergencies faced by the poor, including energy. These monies pay for intervening in a crisis, providing donated goods or cash, and setting the family back on a normal course before long-term dependency or even family break-up sets in. Our state and local officials tell us it is less and less possible to intervene effectively to keep a family from becoming a major consumer of federal and state aid.

o Fifteen percent underwrite the raising and coordinating of resources from states, local governments, businesses and charities in low-income communities. CSBG-funded activities generate 1.3 times as much local and private funding for the poor as the CSBG dollars.

o The rest of the funds (59%) provide direct services not otherwise available.

I would like to offer the draft report summary and an article on Rural Poverty from ***Newsweek*** of August 8 of last year. It tells of 4 rural poor families; all who were not migrant farmworkers have only one place to get help: their local Community Action Agency.

However, Mr. Chairman, the local CSBG system has grown and the funding has not. Most of American's counties are now served by Community Action or other CSBG agencies and the number of these agencies is growing about 4% each year. Minimum wage legislation will raise their costs as well. The institutional foundation for serving our poor is weakening and unless we begin to build it back, the other critical programs in employment, energy, nutrition, and education that Community Action delivers will lose.

Mr. Chairman, Low-Income Energy Assistance is the other cornerstone of assistance for the poor that cannot be cut.

o LIHEAP figures for this past winter are not available yet, but in Iowa, as in Pennsylvania, benefits were cut and people faced crises in spite of milder weather.

o The Administration claims about oil overcharge funding availability are simply false, and I would like to offer a summary of the National Consumer Law Center study of DOE for your records.

o The poor are still desperately needy. LIHEAP recipients spend 13.2% of their entire income on heat, hot water, and lights, where most of us spend 2 or 3%. Further, HHS reports nearly 2 million poor households spent an average of nearly 3 weeks with no heat in mid-winter of 1984, when LIHEAP funding was much higher. These are also the most recent figures available.

In closing, Mr. Chairman, we appreciate the difficulty of your job and the complexity of the problems with which we are faced. Our hope is that the Subcommittee will find a way to maintain these two fundamental and necessary programs, CSBG and LIHEAP, at current service levels or higher.

EXECUTIVE SUMMARY

Information on the uses and impact of the portion of the FY1987 Community Services Block Grant (CSBG) administered through the states was collected in 1988 by the National Association for State Community Services Programs (NASCSP), the national association representing the state administrators of the CSBG, under a

grant from the U.S. Department of Health and Human Services' Office of Community Services.

All 50 states, Puerto Rico, and the District of Columbia responded to all or part of NASCSP's CSBG survey. Data provided by 48 states, D.C., and Puerto Rico were in a format suitable for inclusion in the database.

The results show that a stable set of state and local agencies, administrative arrangements, and federal and state policies are serving a growing low-income clientele with a wide range of direct services, case management support, and advocacy resources.

Although funding for the CSBG remained at its FY1985 levels in FY1987, the CSBG client population continued to grow as the states expanded the numbers of local CSBG subgrantee agencies by 8.5 percent over FY1985, bringing services into previously unserved geographical areas. The sources of funding for the purposes of the Community Services Block Grant, the uses to which these resources were put, the mix of programs and services provided by local CSBG subgrantee agencies, and the states' management of the block grant portion of the FY1987 Community Services Block Grant remained similar to the patterns established in previous years.

FY1987 CSBG FUNDING

Congress appropriated a total of $404,336,000 for the Community Services Block Grant in FY1987, of which $335 represents the block grant portion to the states used for state and local CSBG programs.

In FY1987, appropriations by 15 State Legislatures and transfers from the Low-Income Home Energy Assistance Block Grant in five states provided a net increment of 8 percent, or $23.3 million, to federal CSBG appropriations.

STATE USES OF THE CSBG

The states distributed 92 percent of this block grant portion of the CSBG to Community Action Agencies and other subgrantee agencies designated by statute as local CSBG eligible entities.

States reported using an average of 4.38 percent of their CSBG funding for discretionary grants. Of the $12.6 million for discretionary programs used in 37 of these states in FY1987, $1.2 million was spent on expansion of funding to new eligible entities; $2.7 million was used to fund tribal and migrant farmworker organizations; and $2.4 million was used for statewide anti-poverty projects, including needs assessments and demonstration activities such as family self-sufficiency case management strategies. Most of the balance was devoted to competitive grants to agencies pioneering new responses to the causes of poverty.

THE COMMUNITY SERVICES LOCAL SYSTEM

The local CSBG agencies which receive over 90 percent of state CSBG funds meet criteria set out in the CSBG statute. 73 percent are Community Action Agencies having boards made up of local officials, private sector leaders, and democratically selected representatives of the low-income community. The rest are units of local government, migrant and seasonal farmworker organizations, Indian tribes, and limited purpose agencies.

Nine hundred agencies serve most areas in the 48 states reporting, the District of Columbia and Puerto Rico. Often, they administer a wide variety of federal, state, and local programs as well as initiatives in partnership with the local private sector. The report offers a broad overview of the full range of activities of the CSBG-supported network. It examines only the uses of the block grant funds in depth and describes the role these funds play in the context of the agencies' entire programs.

Although CSBG contributes a small percentage of all funding available to the local system, its functions and unique contributions can be understood through the descriptive materials provided by the states.

In FY1987, CSBG-supported agencies (in the 42 states reporting this information) administered nearly $2.5 billion in federal, state, and local, public and private programs, when all cash and in-kind contributions are taken into account. Of this $2.4 billion, 76 percent came from other federal sources. Of the other federal funds: 24.6 percent were Head Start program funds; 35.4 percent were from the Department of Health and Human Services' Low Income Home Energy Assistance Program (LIHEAP) and the Department of Energy's Weatherization Assistance Program (DOE/WAP); 12 percent were from the Department of Labor's Job Training Partnership Act (JTPA) program; 5.1 percent were funds from the Department of Housing and Urban Development's (HUD) Community Development Block Grant (CDBG) program; and the rest came from the U.S. Department of Agriculture's food programs; ACTION Agency programs; the Social Services Block Grant (SSBG) programs; homeless assistance program funds administered through the Federal Emergency Management Agency (FEMA); HUD's Section 8 rental assistance program; and the Women's Infants' and Children's (WIC) Supplemental Food Program.

State funds from state CSBG programs and other state categorical programs, including health care, substance abuse, child care, child protective services, and programs for the homeless made up 6 percent of the total funds administered by local CSBG subgrantee agencies. Local resources for such activities as senior programs, child care, and information and referral, as well as support for agency administration constituted 5 percent of the total resources administered by these agencies, and private resources made up 6 percent.

The data show that in FY1987, local CSBG subgrantees in these 42 states generated over $254 million of private and local funds alone, or 131 percent of their CSBG funding, for the low-income areas they serve. Local agencies also mobilized millions of volunteer hours at a value of $1 of volunteer time (using minimum wage as a basis) for each $2.89 of CSBG funds.

LOCAL AGENCY USES OF CSBG FUNDS

CSBG funds make up 8 percent of total local agency funding. Community Action Agencies and other local CSBG subgrantee agencies use these modest sums of CSBG in conjunction with funding from other sources, but the data show that the CSBG funds are generally used for purposes that are distinct from those for which funding from other sources is used.

In administering programs from all sources, the data show that local agencies perform three kinds of roles. They serve as the final distribution point for direct services to the poor from many sources. They are coordinators of resources offered by other agencies, groups, and charities in the community; and they serve as catalysts or advocates for solutions to the causes of poverty in their communities including the creation of new programs or institutions appropriate to local needs.

Thirty-one states, whose funding amounted to 58 percent of available CSBG resources, reported detailed information on their uses of the FY87 CSBG funds.

- 20% were used for Emergency Services;
- 14% were used for Nutrition Programs;
- 13% were used for Employment Programs;
- 8% were used for Education Initiatives;
- 8% were used for Information and Referral to programs other than those listed above;
- 8% were used for Organizing and Advocacy;
- 8% were used for Neighborhood and Economic Development;
- 8% were used for Income Management Programs;
- 7% were used for a variety of other services from elderly independent living programs, to transportation, primary medical and youth services; and
- 6% were used for Housing initiatives.

The report examines each program area in detail and provides a profile of CSBG-funded activities in each category and the role of these activities in relation to other agency functions in the same program area. Examples of CSBG local initiatives are cited.

The descriptions of CSBG-funded activities provided in the report show that local CSBG subgrantee agencies generally use CSBG funds in the following ways to supplement activities and services available under other federal, state and local programs:

- Adding direct services to those available under other programs. (Such as, providing chores and household care to disabled medicaid recipients who would be institutionalized otherwise; providing tenant advocates to help renters retain low-income units; and teaching Head Start parents to read; and underwriting the costs of distributing federal commodities or private charitable donations.)

- Serving unserved clients with resources like those provided to others. (Such as, offering low-cost energy conservation materials to households on the DOE Weatherization waiting list; managing drop-out prevention efforts for youth at risk not participating in Aid to Families with Dependent Children (AFDC) program efforts; and creating job and training opportunities for unemployed persons who lack skills to qualify for JTPA programs.)
- Providing the entry-point to the local service network by offering needs assessment, information and referral and direct emergency support for persons in crisis; and other activities which manage the selection of resources to meet client needs.
- Coordinating other programs, especially through counseling and long term case management of persons receiving a variety of benefits; and
- Initiating new programs appropriate to local needs and institutions to eliminate causes of poverty.

AGENCY ROLES FUNDED BY THE CSBG

If CSBG expenditures are grouped by function of the local agencies instead of by categorical services, 59 percent were spent on direct services to households, 25 percent funded case management and individual counseling and referral activities, and 15 percent funded agencies' work as advocates, designers of new initiatives, and coordination of community resources for the poor. A minimal amount was spent directly on activities jointly funded by private parties or local government.

Because only a few states currently collect unduplicated client counts, there is insufficient data to provide a national count of clients served under the CSBG. The 39.5 million 'clients served' reported by 40 state agencies is a hybrid figure combining participant counts for individual programs with units-of-service for programs in some of the states. No reliable information on client characteristics is currently available. However, the data that are available show most local activities involve low CSBG expenditures per unit of service, further confirming the incremental and highly leveraged uses of CSBG funds.

STATE ADMINISTRATION OF THE CSBG

In addition to detailed information summarized above on how the CSBG operates on the local level, the report includes a review of state administration of the Block Grant and finds increases in state CSBG appropriations, increasing variety in the location of CSBG management, and stability in state legislative requirements, local agency designation, and administrative costs.

The narrative that follows is the first attempt to present the data collected on the CSBG program operations in a way that provides a description of the nature and impact of the state and local CSBG network as well as an FY1987 program management review. NASCSP expects to provide additional and expanded analysis of the impact of the Community Services Block Grant in future years. While the diversity of activities makes description and quantification of state CSBG programs difficult, this report reflects the ability of the state and local CSBG system to adapt the block grant resources to meet the particular, local needs of low-income communities across the nation.

February, 1989

INTRODUCTION[1]

This report was prepared by the National Consumer Law Center under a grant from the U.S. Department of Energy and is the second of four quarterly reports to be provided under this grant.[2]

This report incorporates information collected by NCLC in telephone surveys conducted from late-January through February, 1989. As with the previous report, the information we collected on the status and state uses of both Exxon and Stripper Well funds is contained in a series of tables and in the narrative summary section of the report.

Under the terms of the DOE grant, each of the quarterly reports tracks final state decisions allocating use of these funds. The terms "allocated" and "designated" are used interchangeably throughout the document to mean that final state decisions have been made regarding these funds. Tracking state allocations about these funds is the only practical way for us to provide an overview of the actual status of state processes or decisions which have occurred with regard to this money.

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[1] This report was prepared by Helen Gonzales, Staff Attorney, with the assistance of Ralph DiPietro, who served as law clerk in the Center's Washington, D.C. Office during the survey period.

[2] Grant No. DE-FG02-88CH10381 was awarded to NCLC on August 15, 1988, at the request of the Congress, in PL 100-202 (12/87).

Focusing only on state expenditures, or even obligations, of these funds does *not* provide a true picture of state activity in this area. The same is true with regard to submissions to or authorizations by the U.S. Department of Energy (DOE). Most states have adopted multi-year allocation plans; however, since DOE is only required to approve expenditures on a year to year basis (and states need only submit planned expenditures 30 days before they are made), the data that DOE officially receives from a state may only reflect partial allocation plans. Where available, however, the status of DOE review of a state's allocation is noted in the narrative summary section.

By focusing on final state decisions, or allocations, NCLC's reports give recognition to the subsequent activity which occurs following a final state allocation of these oil overcharge funds. In most states, for example, after a Governor and/or state legislature adopt a multi-year plan which designates specific amount of funds to certain programs, it is then up to the responsible state agencies to choose (through the Request For Proposal process, or otherwise) and fund individual projects within those programs. The likelihood that most states will be willing to revisit their decision-making with regard to these funds is not high, given the practical considerations that are a part of that process. For all intents and purposes, then, this allocated money is "committed," even if it may not be obligated under a contract.

II. STATE USES OF OIL OVERCHARGE FUNDS: STATUS REPORT

As indicated at the outset, this is the second of four quarterly reports to be prepared for DOE on the status of state uses of the *Exxon* and *Stripper Well* oil overcharge funds. The current report reflects state information gathered by telephone from late-January through February, 1989.

Summary Findings

Between the time of our last report and the beginning of the surveying for this report (in late-January), the states received another $12.9 million of *Stripper Well* funds. While only a small amount of money, this distribution by the Department of Energy slightly changed the amount, and percentage, allocations of these funds.

Our survey revealed that of the **total $3.05 billion of *Exxon* and *Stripper Well* funds that the states had received from 1986 through January, 1989 (when our survey began), 95.4%, or $2.91 billion, had been allocated.** This figure represents an additional allocation of only 2.2%, or another of $80,000, from the amount allocated during the survey period of our first report (*i.e.,* last fall). Further, we found that 22 states had already allocated 80% - 100% of these combined *Exxon* and *Stripper Well* funds (down by 8 states since our last report, due to the additional allocation of *Stripper Well* funds and to revisions made to the allocation amounts, by the states). Specifically, 12 states had made final decisions, or allocations, regarding all of both their *Exxon* and their 1986 through January, 1989, *Stripper Well* funds. An additional 15 states had 10% or less of their total funds left unallocated, while another 7 states had only 11-20% of their total money for which final decisions had not yet been made.

Allocation of Exxon Funds. In 1986, the states and U.S. Territories received $2.1 billion from the oil overcharge judgment against the Exxon Corporation; the state's share of this amount was $2.057 billion. According to our recent survey, 99% (or $2.044 billion) of the states' share of this money had been allocated.

Furthermore, thirty-nine (39) states had allocated all, or virtually all (95%-99%), of their *Exxon* money, while another 5 states had only 16-20% of these funds still unallocated. As we pointed out in our first report, this figure is significant because since the use of these funds is limited to only five programs, with the two larger programs serving low-income consumers, states have been more willing to use this money, rather than *Stripper Well* money, for low-income purposes; in fact, **one-half of the allocated *Exxon* funds (or $1.012 billion) had been designated for LIHEAP or WAP. The division of funds between LIHEAP and WAP was $483.65 million (or 24%) for LIHEAP and $529.02 million (or 26%) for WAP.** (The percentage share for the two programs has basically remained the same, since the first report.) It should be noted that a large amount of the funds designated for LIHEAP were intended to be used for weatherization.

All but one state had allocated roughly 50% (48% or more) of these *Exxon* funds. We found that 12 states *had not* used any funds for LIHEAP; 8 of these states had already allocated 100% of their *Exxon* money. Five states *had not* designated any money for WAP; 3 of these states had allocated 100% of their funds. One state had *not* allocated any funds for either LIHEAP or WAP (it had allocated 24% of its *Exxon* funds), while another state (which had allocated 59% of its funds) had allocated less than 1% to these programs. Eight (8) states had allocated 25% or less of their funds for LIHEAP or WAP. Some states had also designated some of their SECP or EES money for low-income outreach and other uses aimed at low income households, for a total of at least $13.52 million (*see* Table 3 for list of which states have made these identifiable low-income uses).

Use of Stripper Well Funds. From 1986 through January, 1989, the states received a total of $990.36 million under the terms of the *Stripper Well* agreement. Our survey revealed that 88% (or $868.03 million) had been allocated. **All but one state had made some *Stripper Well* allocations and only six states had not allocated roughly 50% of these funds.** We found that 22 states had allocated all or virtually all (95-99%) of their funds. Specifically, thirteen (13) states had allocated all of their funds, while another 11 states had allocated 95% or more of this money. Another nine (9) states had only 6% to 10% of these funds unallocated, while a further eight (8) states had only 11-20% of funds still left to designate.

We found that states had used about 28% of the $868.03 million in *Stripper Well* money they had allocated for exclusively low-income programs; these programs include LIHEAP and WAP, as well as other low-income projects. Of the $243.42 million allocated for low-income programs, LIHEAP had received $106.73 million (or 12%) while WAP had received $57.36 million (or 7%). The other $79.33 million (or 9%) designated for low-income uses were being spent through programs other than LIHEAP or WAP. Excluding the one state which has not yet made any allocations, 27 states had *not* allocatetd any funds for LIHEAP and 33 had not allocated any funds for WAP. Four (4) states had *not* allocated any funds for LIHEAP, WAP, or any other low-income uses, although one of these states (NC) had allocated 100% of the funds they had so far allocated for primarily, but not exclusively, low-income uses (so its allocation is shown in the "Other" category).

EXXON: SUMMARY ALLOCATIONS
[NUMBERS IN MILLIONS]

TABLE 1

FEBRUARY, 1989

STATE	TOTAL RECEIVED	AMOUNT ALLOCATED	LIHEAP	WAP	SECP	EES	SECP/EES	ICP	OTHER USES
AL	$32.19	$32.38	$5.50	$5.00	$5.25	$3.25		$12.00	$1.38
AK	$8.27	$8.70		$6.29			$1.49	$0.90	
AZ	$21.56	$14.08	$1.50	$4.00	$6.15	$0.25		$1.50	$0.68
AR	$25.95	$29.31	$4.80	$2.50	$2.01			$20.00	
CA	$194.72	$214.78	$66.36		$61.33		$79.80	$5.29	$2.00
CO	$22.71	$25.33		$4.71			$20.61		
CT	$34.90	$37.00	$29.60		$1.75		$4.52	$1.20	
DE	$9.9[illegible]	$8.68	$0.19	$3.00	$0.10	$0.04		$5.35	
DC	$4.[illegible]	$4.67	$2.07	$0.90	$1.00	$0.30		$0.40	
FL	$98.11	$57.93		$0.20	$16.10	$1.90		$39.70	
GA	$46.62	$55.60	$21.00	$14.70	$1.50	$2.40		$16.00	
HI	$14.48	$14.50		$1.00	$4.62	$1.63		$4.25	
ID	$8.69	$8.95		$3.28	$3.87			$1.80	
IL	$96.10	$115.00	$40.00	$62.55	$12.45				
IN	$51.63	$54.08	$20.90	$13.70	$8.81	$10.27		$0.40	
IA	$27.42	$24.13		$6.17	$12.61	$5.35			
KS	$23.96	$19.13	$10.84	$1.00	$2.49	$0.09		$4.72	
KY	$27.44	$13.11	$4.62	$8.49					
LA	$51.54	$51.54		$11.54			$10.00	$30.00	
ME	$15.09	$16.50	$0.20	$7.60	$6.70	$1.00		$1.00	
MD	$36.41	$40.35	$4.30	$30.00	$2.11	$0.94		$3.00	
MA	$70.34	$72.50	$9.85	$42.15	$20.50				
MI	$70.99	$79.30	$47.60	$13.00			$18.67		
MN	$36.07	$36.45	$5.50	$5.50	$14.30		$11.15		
MS	$28.38	$29.95	$2.37	$7.61	$5.10	$0.25	$2.12	$12.50	
MO	$41.52	$41.49	$3.86	$15.25	$11.29	$0.50		$10.59	
MT	$9.58	$10.55		$4.87	$2.90	$0.23		$0.90	$1.65
NE	$15.50	$3.67			$2.49	$1.18			
NV	$8.77	$7.53	$3.27	$2.51	$0.51	$1.02		$0.22	
NH	$9.80	$11.43	$0.75	$1.17	$5.16	$3.85		$0.50	
NJ	$75.43	$67.50	$43.50		$4.00			$20.00	
NM	$13.69	$15.92	$3.09	$3.61	$3.97	$1.03		$3.74	
NY	$159.87	$173.50	$17.00	$39.40	$72.00	$14.00		$31.10	
NC	$47.03	$27.54	$6.64	$7.40			$8.50	$5.00	
ND	$7.72	$8.30	$2.80	$1.30	$0.40	$0.10	$0.90	$2.70	
OH	$79.74	$78.00	$12.00	$50.30			$12.40	$3.30	
OK	$26.23	$30.10	$6.54	$5.31			$12.98	$4.00	
OR	$20.72	$22.31	$3.18	$10.71	$5.34	$0.03			$3.05
PA	$96.80	$106.00	$66.10	$31.30			$8.60		
RI	$8.00	$8.05	$0.55	$1.34	$3.31	$1.34		$1.50	
SC	$25.19	$29.30	$7.50	$8.60	$4.50	$4.40		$4.30	
SD	$7.50	$8.77	$1.56		$5.74	$0.41		$1.00	$0.06
TN	$34.60	$35.50	$3.50	$18.00	$4.00			$10.00	
TX	$157.19	$153.40	$2.00	$7.00	$130.10	$9.00		$8.00	
UT	$12.45	$13.20		$5.50	$5.50	$0.45		$1.75	
VT	$5.00	$5.66	$0.36	$3.00			$2.30		
VA	$53.38	$39.10	$14.10	$15.20	$6.40	$0.42		$3.00	
WA	$32.12	$41.59	$1.00	$15.13	$16.38	$0.77		$6.44	$1.87
WV	$12.90	$15.45	$7.15	$4.53	$3.03	$0.27		$0.47	
WI	$36.97	$17.70		$17.70					
WY	$8.87	$9.00		$2.00	$5.00			$2.00	
TOTALS:	$2,064.75	$2,044.51	$483.65	$529.02	$480.77	$66.67	$194.04	$280.52	$10.69

TABLE 2

EXXON FUNDS: LOW INCOME USES
(NUMBERS IN MILLIONS)

FEBRUARY, 1989

STATE	TOTAL RECD.	AMOUNT ALLOC.	PCT OF RECD. $ ALLOC.	LIHEAP	LIHEAP PCT.	DOE WAP	WAP PCT.	LIHEAP & WAP AMT.	LIHEAP & WAP PCT.
AL	$32.19	$32.38	101%	$5.50	17%	$5.00	15%	$10.50	32%
AK	$8.27	$8.70	105%		0%	$6.29	72%	$6.29	72%
AZ	$21.56	$14.08	65%	$1.50	11%	$4.00	28%	$5.50	39%
AR	$25.95	$29.31	113%	$4.80	16%	$2.50	9%	$7.30	25%
CA	$194.72	$214.78	110%	$66.36	31%		0%	$66.36	31%
CO	$22.71	$25.33	112%		0%	$4.71	19%	$4.71	19%
CT	$34.90	$37.00	106%	$29.60	80%		0%	$29.60	80%
DE	$9.94	$8.68	87%	$0.19	2%	$3.00	35%	$3.19	37%
DC	$4.60	$4.67	102%	$2.07	44%	$0.90	19%	$2.97	64%
FL	$98.11	$57.93	59%		0%	$0.20	0%	$0.20	0%
GA	$46.62	$55.60	119%	$21.00	38%	$14.70	26%	$35.70	64%
HI	$14.48	$14.50	100%		0%	$4.00	28%	$4.00	28%
ID	$8.69	$8.95	103%		0%	$3.28	37%	$3.28	37%
IL	$96.10	$115.00	120%	$40.00	35%	$62.55	54%	$102.55	89%
IN	$51.63	$54.08	105%	$20.90	39%	$13.70	25%	$34.60	64%
IA	$27.42	$24.13	88%		0%	$6.17	26%	$6.17	26%
KS	$23.96	$19.13	80%	$10.84	57%	$1.00	5%	$11.84	62%
KY	$27.44	$13.11	48%	$4.62	35%	$8.49	65%	$13.11	100%
LA	$51.54	$51.54	100%		0%	$11.54	22%	$11.54	22%
ME	$15.09	$16.50	109%	$0.20	1%	$7.60	46%	$7.80	47%
MD	$36.41	$40.35	111%	$4.30	11%	$30.00	74%	$34.30	85%
MA	$70.34	$72.50	103%	$9.85	14%	$42.15	58%	$52.00	72%
MI	$70.99	$79.30	112%	$47.60	60%	$13.00	16%	$60.60	76%
MN	$36.07	$36.45	101%	$5.50	15%	$5.50	15%	$11.00	30%
MS	$28.38	$29.95	106%	$2.37	8%	$7.61	25%	$9.98	33%
MO	$41.52	$41.49	100%	$3.86	9%	$15.25	37%	$19.11	46%
MT	$9.58	$10.55	110%		0%	$4.87	46%	$4.87	46%
NE	$15.50	$3.67	24%		0%		0%	$0.00	0%
NV	$8.77	$7.53	86%	$3.27	43%	$2.51	33%	$5.78	77%
NH	$9.80	$11.43	117%	$0.75	7%	$1.17	10%	$1.92	17%
NJ	$75.43	$67.50	89%	$43.50	64%		0%	$43.50	64%
NM	$13.69	$15.92	116%	$3.09	19%	$3.61	23%	$6.70	42%
NY	$159.87	$173.50	109%	$17.00	10%	$39.40	23%	$56.40	33%
NC	$47.03	$27.54	59%	$6.64	24%	$7.40	27%	$14.04	51%
ND	$7.72	$8.30	108%	$2.80	34%	$1.30	16%	$4.10	49%
OH	$79.74	$78.00	98%	$12.00	15%	$50.30	64%	$62.30	80%
OK	$26.23	$30.10	115%	$6.54	22%	$5.31	18%	$11.85	39%
OR	$20.72	$22.31	108%	$3.18	14%	$10.71	48%	$13.89	62%
PA	$96.80	$106.00	110%	$66.10	62%	$31.30	30%	$97.40	92%
RI	$8.00	$8.05	101%	$0.55	7%	$1.34	17%	$1.89	23%
SC	$25.19	$29.30	116%	$7.50	26%	$8.60	29%	$16.10	55%
SD	$7.50	$8.77	117%	$1.56	18%		0%	$1.56	18%
TN	$34.60	$35.50	103%	$3.50	10%	$18.00	51%	$21.50	61%
TX	$157.19	$153.40	98%	$2.00	1%	$7.00	5%	$9.00	6%
UT	$12.45	$13.20	106%		0%	$5.50	42%	$5.50	42%
VT	$5.00	$5.66	113%	$0.36	6%	$3.00	53%	$3.36	59%
VA	$53.38	$39.10	73%	$14.10	36%	$15.20	39%	$29.30	75%
WA	$32.12	$41.59	129%	$1.00	2%	$15.13	36%	$16.13	39%
WV	$12.90	$15.45	120%	$7.15	46%	$4.53	29%	$11.68	76%
WI	$36.97	$17.70	48%	-	0%	$17.70	100%	$17.70	100%
WY	$8.87	$9.00	101%		0%	$2.00	22%	$2.00	22%
TOTALS	$2,064.68	$2,044.51	99%	$483.65	24%	$529.02	26%	$1,012.67	50%

EXXON FUNDS: OTHER USES
[NUMBERS IN MILLIONS]

TABLE 3

FEBRUARY, 1989

STATE	TOTAL RECEIVED	AMOUNT ALLOCATED	SECP	EES	SECP/EES	ICP	OTHER USES	NOTES
AL	$32.19	$32.38	$5.25	$3.25		$12.00	$1.38	
AK	$8.27	$8.70			$1.49	$0.90		Some SECP funds for primarily low-income use
AZ	$21.56	$14.08	$6.15	$0.25		$1.50	$0.68	$680,000 to Navajo Nation, for weatherization
AR	$25.95	$29.31	$2.01			$20.00		
CA	$194.72	$214.78	$61.33		$79.80	$5.29	$2.00	Other $ for housing rehab. for farmwrkrs,elderly,handicapped
CO	$22.71	$25.33			$20.61			
CT	$36.90	$37.00	$1.75		$4.52	$1.20		
DE	$9.94	$8.68	$0.10	$0.04		$5.35		
DC	$4.60	$4.67	$1.00	$0.30		$0.40		
FL	$98.11	$57.93	$16.10	$1.90		$39.70		
GA	$46.62	$55.60	$1.50	$2.40		$16.00		About $1.2 million of EES funds for low-income projects
HI	$14.48	$14.50	$4.62	$1.63		$4.25		
ID	$8.69	$8.95	$3.87			$1.80		
IL	$96.10	$115.00	$12.45					SECP includes $1.25 million for low-income uses
IN	$51.63	$54.08	$8.81	$10.27		$0.40		
IA	$27.42	$24.13	$12.61	$5.35				
KS	$23.96	$19.13	$2.49	$0.09		$4.72		SECP includes $315,000 for low-income uses
KY	$27.44	$13.11						
LA	$51.54	$51.54			$10.00	$30.00		
ME	$15.09	$16.50	$6.70	$1.00		$1.00		
MD	$36.41	$40.35	$2.11	$0.94		$3.00		
MA	$70.34	$72.50	$20.50					
MI	$70.99	$79.30			$18.67			$900,000 of SECP/EES $ for low-to-moderate income use
MN	$36.07	$36.45	$14.30		$11.15			$7.5 million of SECP $ for low-to-moderate income uses
MS	$28.38	$29.95	$5.10	$0.25	$2.12	$12.50		
MO	$41.52	$41.49	$11.29	$0.50		$10.59		$50,000 of SECP/EES $ for homeless energy conservation
MT	$9.58	$10.55	$2.90	$0.23		$0.90	$1.65	Reserved for LIHEAP and/or WAP
NE	$15.50	$3.67	$2.49	$1.18				
NV	$8.77	$7.53	$0.51	$1.02		$0.22		
NH	$9.80	$11.43	$5.16	$3.85		$0.50		$450,000 EES $ for energy improvements in public housing
NJ	$75.43	$67.50	$4.00			$20.00		
NM	$13.69	$15.92	$3.97	$1.03		$3.74		
NY	$159.87	$173.50	$72.00	$14.00		$31.10		$12 million of EES $ for low-to-moderate inc. uses
NC	$47.03	$27.54			$8.50	$5.00		
ND	$7.72	$8.30	$0.40	$0.10	$0.90	$2.70		
OH	$79.74	$78.00			$12.40	$3.30		SECP/EES: $3.7 million for low & moderate inc. uses
OK	$26.23	$30.1[illegible]			$12.98	$4.00		
OR	$20.72	$22.31	$5.34	$0.03			$3.05	$3.05m for cutbacks in LIHEAP/WAP;$820,000 SECP for low-inc.
PA	$96.80	$106.00			$8.60			
RI	$8.00	$8.05	$3.31	$1.34		$1.50		
SC	$25.19	$29.30	$4.50	$4.40		$4.30		
SD	$7.50	$8.77	$5.74	$0.41		$1.00	$0.06	$.06 for tribal government LIHEAP
TN	$34.60	$35.50	$4.00			$10.00		
TX	$157.19	$153.40	$130.10	$9.00		$8.00		
UT	$12.45	$13.20	$5.50	$0.45		$1.75		
VT	$5.00	$5.66			$2.30			$200,000 of SECP/EES funds for low-income use
VA	$53.36	$39.10	$6.40	$0.42		$3.00		
WA	$32.12	$41.59	$16.38	$0.77		$6.44	$1.87	$1.8mil/$1.87m=low-inc:$2.88m of SECP $ =low-mod.inc.uses
WV	$12.90	$15.45	$3.03	$0.27		$0.47		
WI	$36.97	$17.70						
WY	$8.87	$9.00	$5.00			$2.00		
TOTALS:	$2,064.68	$2,044.51	$480.77	$66.67	$194.04	$280.52	$10.69	

STRIPPER WELL: SUMMARY ALLOCATIONS TABLE 4 FEBRUARY, 1989
[NUMBERS IN MILLIONS]

STATE	AMOUNT RECEIVED 3/86-1/89	AMOUNT ALLOCATED	LIHEAP	DOE WAP	OTHER LOW-INC	OTHER PROGRAMS
AL	$15.44	$15.29	$2.27			$13.02
AK	$3.89	$0.00				
AZ	$10.32	$9.93			$3.80	$6.13
AR	$12.81	$12.53	$2.08	$2.92		$7.53
CA	$92.13	$90.94	$15.50			$116.00
CO	$10.82	$10.72		$2.01	$1.68	$7.03
CT	$17.09	$18.35			$4.92	$13.42
DE	$4.78	$4.15		$1.00		$3.15
DC	$2.40	$2.20	$0.06		$0.68	$1.46
FL	$46.50	$33.85		$13.25		$20.60
GA	$22.41	$22.45	$4.25		$3.75	$14.45
HI	$6.91	$1.00				$1.00
ID	$4.13	$3.82			$0.16	$3.66
IL	$46.22	$46.05	$11.50			$34.55
IN	$24.79	$22.64	$2.28		$3.16	$17.20
IA	$13.11	$11.03			$0.35	$10.68
KS	$11.28	$2.87			$0.11	$2.76
KY	$12.90	$4.76	$3.18		$0.58	$1.00
LA	$23.94	$25.09			$5.02	$20.07
ME	$7.40	$7.28	$1.60		$1.07	$4.61
MD	$18.02	$19.93	$7.34	$4.49	$2.57	$5.53
MA	$34.45	$28.00	$10.00			$18.00
MI	$34.29	$42.36	$14.60	$6.70		$21.30
MN	$17.46	$16.67		$8.30		$8.37
MS	$13.74	$12.70	$1.34	$1.25		$10.11
MO	$19.87	$16.76	$2.08	$2.86		$11.82
MT	$4.55	$3.68			$1.05	$2.63
NE	$7.42	$0.75		$0.65		$0.10
NV	$4.08	$5.18	$0.35		$0.08	$4.75
NH	$4.69	$4.45		$0.98	$0.44	$3.03
NJ	$37.15	$35.00				$35.00
NM	$6.59	$7.50		$0.10		$7.40
NY	$77.93	$70.00		$7.60	$6.00	$56.40
NC	$22.59	$21.00				$21.00
ND	$3.69	$3.64	$1.00			$4.50
OH	$37.82	$26.00			$10.50	$15.50
OK	$12.43	$12.67	$0.60	$0.02	$2.20	$9.85
OR	$9.97	$11.31		$1.74	$0.60	$8.97
PA	$46.86	$21.50	$14.40			$7.10
RI	$3.99	$3.62	$2.20			$1.42
SC	$12.00	$10.60		$1.00	$1.00	$8.60
SD	$3.60	$3.85			$0.12	$3.56
TN	$16.28	$5.00	$1.00			$4.00
TX	$74.25	$70.50	$7.00		$5.00	$58.50
UT	$5.94	$5.00				$5.00
VT	$2.41	$1.56		$1.35		$0.21
VA	$25.83	$20.60			$20.00	$0.60
WA	$15.37	$15.98	$1.00	$1.14	$1.88	$11.05
WV	$6.01	$5.65			$0.25	$5.40
WI	$17.71	$17.50			$2.10	$15.40
WY	$4.10	$4.12	$1.10		$0.26	$2.76
TOTALS:	$990.36	$868.03	$106.73	$57.36	$79.33	$666.18

STRIPPER WELL: LOW INCOME USES
[NUMBERS IN MILLIONS]

TABLE 5

FEBRUARY, 1989

STATE	AMOUNT RECEIVED 3/86-1/89	AMT. ALLOC.	PCT. OF RECD. FUNDS ALLOC.	LIHEAP	LIHEAP PCT.	DOE WAP	WAP PCT.	OTHER LOW-INC	OTHER LOW-INC PERCENT	TOTAL LOW-INC. AMT.	TOTAL LOW-INC PERCENT
AL	$15.44	$15.29	99%	$2.27	15%		0%		0%	$2.27	15%
AK	$3.89	$0.00	0%		0%		0%		0%	$0.00	0%
AZ	$10.32	$9.93	96%		0%		0%	$3.80	38%	$3.80	38%
AR	$12.81	$12.53	98%	$2.08	17%	$2.92	23%		0%	$5.00	40%
CA	$92.13	$90.94	99%	$15.50	17%		0%		0%	$15.50	17%
CO	$10.82	$10.72	99%		0%	$2.01	19%	$1.68	16%	$3.69	34%
CT	$17.09	$18.35	107%		0%		0%	$4.92	27%	$4.92	27%
DE	$4.78	$4.15	87%		0%	$1.00	24%		0%	$1.00	24%
DC	$2.40	$2.20	92%	$0.06	3%		0%	$0.68	31%	$0.74	34%
FL	$46.50	$33.85	73%		0%	$13.25	39%		0%	$13.25	39%
GA	$22.41	$22.45	100%	$4.25	19%		0%	$3.75	17%	$8.00	36%
HI	$6.91	$1.00	14%		0%		0%		0%	$0.00	0%
ID	$4.13	$3.82	92%		0%		0%	$0.16	4%	$0.16	4%
IL	$46.22	$46.05	100%	$11.50	25%		0%		0%	$11.50	25%
IN	$24.79	$22.64	91%	$2.28	10%		0%	$3.16	14%	$5.44	24%
IA	$13.11	$11.03	84%		0%		0%	$0.35	3%	$0.35	3%
KS	$11.28	$2.87	25%		0%		0%	$0.11	4%	$0.11	4%
KY	$12.90	$4.76	37%	$3.18	67%		0%	$0.58	12%	$3.76	79%
LA	$23.94	$25.09	105%		0%		0%	$5.02	20%	$5.02	20%
ME	$7.40	$7.28	98%	$1.60	22%		0%	$1.07	15%	$2.67	37%
MD	$18.02	$19.93	111%	$7.34	37%	$4.69	23%	$2.57	13%	$14.60	72%
MA	$34.45	$28.00	81%	$10.00	36%		0%		0%	$10.00	36%
MI	$34.29	$42.36	124%	$14.60	34%	$6.70	16%		0%	$21.30	50%
MN	$17.46	$16.67	95%		0%	$8.30	50%		0%	$8.30	50%
MS	$13.74	$12.70	92%	$1.34	11%	$1.25	10%		0%	$2.59	20%
MO	$19.87	$16.76	84%	$2.08	12%	$2.86	17%		0%	$4.94	29%
MT	$4.55	$3.68	81%		0%		0%	$1.05	29%	$1.05	29%
NE	$7.42	$0.75	10%		0%	$0.65	87%		0%	$0.65	87%
NV	$4.08	$5.18	127%	$0.35	7%		0%	$0.08	2%	$0.43	8%
NH	[illegible]	$4.45	[illegible]		[illegible]	$0.92	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
NJ	$37.15	$35.00	94%		0%		0%		0%	$0.00	0%
NM	$6.59	$7.50	114%		0%	$0.10	1%		0%	$0.10	1%
NY	$77.93	$70.00	90%		0%	$7.60	11%	$6.00	9%	$13.60	19%
NC	$22.59	$21.00	93%		0%		0%		0%	$0.00	0%
ND	$3.69	$3.64	99%	$1.00	27%		0%		0%	$1.00	27%
OH	$37.82	$26.00	69%		0%		0%	$10.50	40%	$10.50	40%
OK	$12.43	$12.67	102%	$0.60	5%	$0.02	0%	$2.20	17%	$2.82	22%
OR	$9.97	$11.31	113%		0%	$1.74	15%	$0.60	5%	$2.34	21%
PA	$46.86	$21.50	46%	$14.40	67%		0%		0%	$14.40	67%
RI	$3.99	$3.62	91%	$2.20	61%		0%		0%	$2.20	61%
SC	$12.00	$10.60	88%		0%	$1.00	9%	$1.00	9%	$2.00	19%
SD	$3.60	$3.85	107%		0%		0%	$0.12	3%	$0.12	3%
TN	$16.28	$5.00	.31%	$1.00	20%		0%		0%	$1.00	20%
TX	$74.25	$70.50	95%	$7.00	10%		0%	$5.00	7%	$12.00	17%
UT	$5.94	$5.00	84%		0%		0%		0%	$0.00	0%
VT	$2.41	$1.56	65%		0%	$1.35	87%		0%	$1.35	87%
VA	$25.83	$20.60	80%		0%		0%	$20.00	97%	$20.00	97%
WA	$15.37	$15.98	104%	$1.00	6%	$1.14	7%	$1.88	12%	$4.02	25%
WV	$6.01	$5.65	94%		0%		0%	$0.25	4%	$0.25	4%
WI	$17.71	$17.50	99%		0%		0%	$2.10	12%	$2.10	12%
WY	$4.10	$4.12	100%	$1.10	27%		0%	$0.26	6%	$1.36	33%
TOTALS:	[illegible]	[illegible]	[illegible]	$106.73	12%	$57.36	7%	$79.33	9%	$243.42	28%

STRIPPER WELL: OTHER USES
(NUMBERS IN MILLIONS)

TABLE 6

FEBRUARY, 1989

STATE	AMOUNT RECEIVED 3/86-1/89	AMOUNT ALLOCATED	OTHER PROGRAMS	SEE REF TABLE
AL	$15.44	$15.29	$13.02	akl
AK	$3.89	$0.00		
AZ	$10.32	$9.93	$6.13	degmtr
AR	$12.81	$12.53	$7.53	aeg
CA	$92.13	$90.94	$116.00	am
CO	$10.82	$10.72	$7.03	adegipru
CT	$17.09	$18.35	$13.42	acdejkmopr
DE	$4.78	$4.15	$3.15	j
DC	$2.40	$2.20	$1.46	dfklru
FL	$46.50	$33.85	$20.60	b
GA	$22.41	$22.45	$14.45	acdfghjlmporu
HI	$6.91	$1.00	$1.00	d
ID	$4.13	$3.82	$3.66	abdfhjmpr
IL	$46.22	$46.05	$34.55	dmu
IN	$24.79	$22.64	$17.20	ak
IA	$13.11	$11.03	$10.68	acfhjr
KS	$11.28	$2.87	$2.76	ah
KY	$12.90	$4.76	$1.00	m
LA	$23.94	$25.09	$20.07	afr
ME	$7.40	$7.28	$4.61	cdefjklmpru
MD	$18.02	$19.93	$5.53	cdejklpr
MA	$34.45	$28.00	$18.00	cdu
MI	$34.29	$42.36	$21.30	ehikru
MN	$17.46	$16.67	$8.37	fghirkl
MS	$13.74	$12.70	$10.11	afhjimpr
MO	$19.87	$16.76	$11.82	imr
MT	$4.55	$3.68	$2.63	dhjkr
NE	$7.42	$0.75	$0.10	r
NV	$4.08	$5.18	$4.75	aemr
NH	$4.69	$4.45	$3.03	jrt
NJ	$37.15	$35.00	$35.00	dp
NM	$6.59	$7.50	$7.40	jmnr
NY	$77.93	$70.00	$56.40	acdfghijkmpr
NC	$22.59	$21.00	·$21.00	u
ND	$3.69	$3.64	$4.50	bjmpr
OH	$37.82	$26.00	$15.50	mru
OK	$12.43	$12.67	$9.85	aefginopu
OR	$9.97	$11.31	$8.97	a
PA	$46.86	$21.50	$7.10	cdehmprs
RI	$3.99	$3.62	$1.42	acdjklpqtr
SC	$12.00	$10.69	$8.60	dhjklp
SD	$3.60	$3.85	$3.56	aeghjr
TN	$16.28	$5.00	$4.00	jkp
TX	$74.25	$70.50	$58.50	aijmmru
UT	$5.94	$5.00	$5.00	fgjr
VT	$2.41	$1.56	$0.21	br
VA	$25.83	$20.60	$0.60	g
WA	$15.37	$15.98	$11.05	abcdhjnpu
WV	$6.01	$5.65	$5.40	a
WI	$17.71	$17.50	$15.40	abcdfhjmnpr
WY	$4.10	$4.12	$2.76	adfhnpru
TOTALS	$990.36	$868.03	$666.18	

REF.	TABLE
a	bridge and road repair and other transportation projects (van pools, public transit uses, etc.)
b	traffic signal synchronization
c	energy conservation projects for non-profits
d	residential energy conservation uses
e	projects for older persons
f	demonstration projects
g	alternate fuel projects
h	agricultural sector projects
i	university sector projects
j	state/local government energy conservation programs
k	SECP (State Energy Conserv. Prog.)
l	EES (Energy Extension Service)
m	Schools & Hospitals Weatherization (through ICP or otherwise)
n	Native American uses
o	energy conservation projects for shelters amt. shown in "Other Low Inc."
p	commercial energy conservation uses
q	pooled Exxon & Stripper Well (&/or other overcharge) funds
r	other uses (includes admin. costs)
s	SECP &/or EES
t	technical assistance for a given sector
u	programs targeted, but not exclusively, for low-income uses and projects for low-to-moderate income persons

Senator Inouye. As you have noted, correctly, for the last 6 years, the administrations have submitted zero requests for the committee grants.

But as you also know, we have provided moneys.

Members of this committee have taken to heart, and very seriously, our President's desire that we be a kinder and gentler Nation, and a kinder and gentler Nation will not forsake its elderly, will not forsake its disabled, will not forsake its children, and will not forsake the poor.

That is the motto of this subcommittee, I can assure you.

Mr. Bradley. I appreciate that.

Senator Inouye. Thank you very much.

STATEMENT OF ANTHONY E. ARD, INDIANA GAS CO., INC., AND AMERICAN GAS ASSOCIATION

Senator Inouye. Our next witness represents the Indiana Gas Co., and the American Gas Association, Mr. Anthony E. Ard.

Mr. Ard. Thank you, Senator Inouye. I am happy to be here.

Senator Inouye. Thank you for appearing, sir.

Mr. Ard. Thank you.

I am here as a spokesman for the American Gas Association. As you probably already know, that is a trade association comprising some 250 gas distribution and transmission companies.

I am here to express our opposition to the administration's proposal to reduce LIHEAP funding by some 21 percent, and to express support for a level of funding of $1.44 billion, which is the fiscal year 1989 appropriation plus an adjustment to reflect inflation.

I suspect, probably, that there is cause that would justify increasing the appropriation even further. I have prepared written testimony which has already been filed with the committee, and additional, more detailed testimony is being prepared and will be presented to the committee in about 1 week. I would ask that you incorporate that too in the record of the committee.

Senator Inouye. As long as you can get it to us by May 15.

Mr. Ard. Certainly.

Senator Inouye. It will be part of the record.

Mr. Ard. OK. Because the hour is getting late, let me just focus on two points in the form of rebuttal to the administration's justification for reducing the LIHEAP appropriation.

One thing that they have expressed is that the amount of the recipients' income devoted to home energy and home heating has declined since 1984. What they neglect to mention is that 1984 was one of the coldest winters of the past 10 years, and they are comparing that against two of the warmest winters—1987 and 1988. So obviously expenditures as a percent of income are going to go down because consumption is going down.

What then happens if we return to more normal winter temperatures, or even worse, have a colder winter as we did in the late 1970's and early 1980's?

The second point that is often expressed, not only by the administration but others, is that there are funds available through the oil overcharge settlement.

The National Consumer Law Association has developed data which indicate that 95 percent of those funds have already been allocated and are no longer available. In Indiana, it is more like 98 percent of those funds which are already allocated and are not available.

As a closing point, I would like to sort of identify two specific aspects which are derived from our Indiana experience. One is that the range of energy expenditure as a percentage of income in Indiana is from 14 to 27 percent, depending upon what particular classification you fall into—either senior citizen or disabled or recipient of SSI, or an AFDC mother.

The second thing that I would like to say about the Indiana experience is that if the Congress did not appropriate the $1.44 billion, but rather adopted the administration proposal, the effect would be, in Indiana, that there would be 51 percent fewer households that could be served with the same amount of dollars. Or, if you served the same amount of households, the allocation per household would be reduced about 38 percent. So, it would have a dramatic fiscal impact on Hoosier citizens.

Senator INOUYE. Fifty-one percent cut?

Mr. ARD. That would be in the number of households—that is right.

Senator INOUYE. At the present level of services?

Mr. ARD. Based on the administration's proposed level of services.

With the current level, we do not have a specific estimate on that, but we could probably sustain at the current level with a current services appropriation, which would be about 135,000 households.

Senator INOUYE. Adding this to a report from meteorologists that this may be a terrible winter, your statistics may be worse?

Mr. ARD. Could be. That is why I wanted to make that point about the administration's justification.

PREPARED STATEMENT

Senator INOUYE. I wish to commend you, because it is oftentimes suggested that business people are not interested in the plight of the poor. Your presence here says otherwise. We thank you, sir.

Mr. ARD. Thank you, Mr. Chairman.

[The statement follows:]

STATEMENT OF ANTHONY E. ARD

Members of the Subcommittee, I am Anthony E. Ard, Vice President and Secretary of the Indiana Gas Company, Inc. I am appearing on behalf of the American Gas Association (A.G.A.), a national trade association of some 250 natural gas distribution and transmission companies. I am here in support of federal funding for the Low-Income Home Energy Assistance Program (LIHEAP). A.G.A. members, including Indiana Gas Company, are deeply committed to meeting the energy needs of all our customers, including those with low or fixed incomes.

LIHEAP has already taken its share of cuts for the sake of trimming the federal deficit. The current FY funding for LIHEAP is $1.383 billion. By proposing an appropriation of $1.1 billion for FY90, the Administration advocates a draconian 21 percent cut over FY89's funding level. LIHEAP cannot survive with any degree of effectiveness if these cuts continue. Consequently, we are supporting a funding level of $1.4 billion, which is the FY89 appropriation plus inflation.

I do not want to imply that the burden of meeting low-income consumers' energy needs rests solely on the shoulders of the federal government. A.G.A. members have a number of innovative programs, including utility fuel funds, that supplement LIHEAP.

In Indiana Gas Company's service area, the reductions in federal appropriations have had a devastating impact on the number of households served by LIHEAP. Indiana's Project SAFE is funded by LIHEAP and assists the poor, elderly and disabled meet their gas, electric and fuel oil bills. Unfortunately, if the administration's proposal is approved, Indiana will have lost 53 percent of federal funds since 1984, resulting in fewer and fewer of the truly needy getting the fuel assistance they need.

The Administration rationalizes further LIHEAP cuts by asserting that energy prices have stabilized and oil overcharge settlement funds are available for assistance. Both assertions require rebuttal.

First, although fuel prices have stabilized, low income families still spend an unduly large proportion of family income for energy. Moreover, the last two winters have been relatively mild, so gas consumption (which tracks the weather) has been down. However, a return to normal or below-normal weather next year would cause an increase in the percent of income devoted to home heating.

Second, oil overcharge settlement funds simply are no longer available in my state, according to the Indiana Department of Human Services. Moreover, the National Consumer Law Center has reported to DOE that 95 percent of these funds that were available nationwide have been allocated by the states. These funds cannot be relied upon to fill the gap left by reduced LIHEAP funds.

Thus, we urge that you recognize LIHEAP as a vital safety net for the disadvantaged of this nation and approve a funding level of $1.4 billion for FY90.

Thank you. We will submit a written statement for the hearing record elaborating on my testimony.

STATEMENT OF JOAN PINCHUK, REFUGEE COORDINATOR, COUNTY OF LOS ANGELES

Senator INOUYE. Our final witness—this does not mean she is not the important one—she may be the most important one—is the refugee coordinator of the county of Los Angeles, Joan Pinchuk.

Thank you for your patience in waiting this long. Just for that, we will give you everything you want.

Miss PINCHUK. I will take it. You are very kind.

And like you said, I may be last, but I do not intend to be least. Please excuse my voice—I think that I am losing it. I have caught a cold, and so I apologize for my tone.

As you said, I am Joan Pinchuk, and I am from Los Angeles County. I represent the county as well as being the refugee coordinator for that county.

I have come here today to talk to you about Federal policy, numbers, and money. As you stated earlier, Federal policy is beyond State and local control, and the Federal policy on refugee admissions is definitely beyond the States' control.

As you are well aware, the refugee admission quotas that are set by our Federal Government and the administration are coming up rapidly. We just 5 years ago were receiving into this country 68,000 refugees. As we talk here today, the administration is proposing to add another 22,000 to 26,000 to our current 94,000 to make it 116,000 admissions this fiscal year.

So, as we speak, we are going in the hole fast. With the appropriations that were approved this past fiscal year, we could be—and I am talking nationwide—$100 million in the hole as we speak here today, if that indeed does come true.

What has happened with the HHS budget is that they make things balance by cutting back and shifting these costs to the State and local government, as well as taking away services from our refugees. Refugees obviously are from various parts of the world and are very needy persons who are coming here to this country for hope, for opportunities.

When they come here and there is nothing for them but waiting lists, and no opportunities to learn our language because our classes are full and there is no money for them; where they do not have skills to get a job and become productive, what is left to them but our Welfare system? Obviously, that is a State and local and Federal cost.

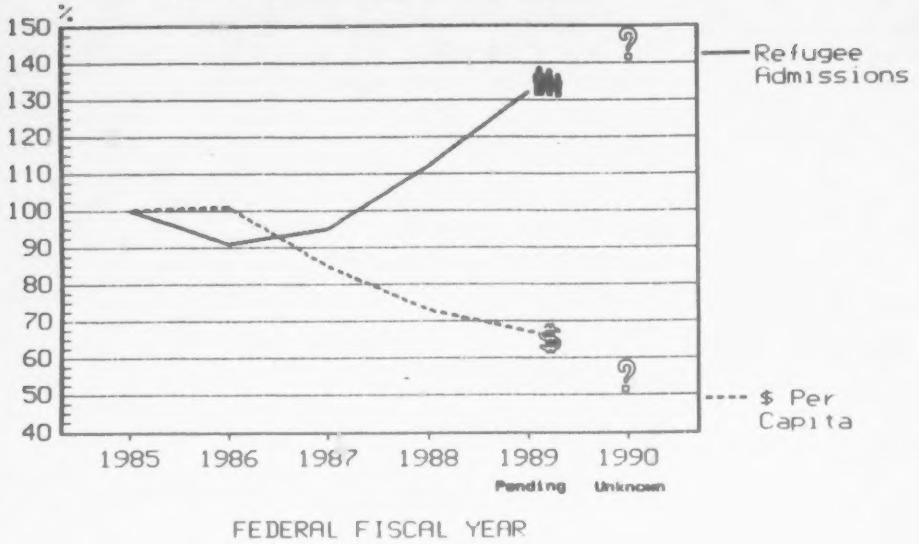
What the Federal Government originally proposed right back in just 1980 is that it takes about 3 years for a refugee to learn the language and acquire the skills where they can be self-supporting, and that is obviously what we all want.

So, what has happened because the admissions are going up—and I have a demonstration of a chart here. You can see, we have our line going up, and here is our little——

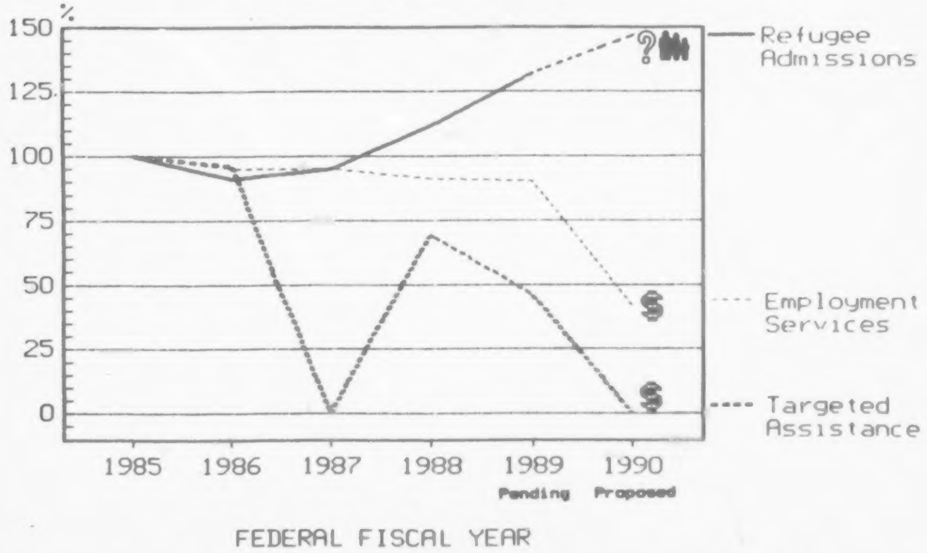
Senator INOUYE. Without objection, that chart will be made part of the record.

Miss PINCHUK. OK, thank you.

[The information follows:]



UNITED STATES
REFUGEE ADMISSIONS vs. $ PER CAPITA
(as a percentage of FY 1985)



UNITED STATES
REFUGEE FUNDING vs. REFUGEE ADMISSIONS
(as a percentage of FY 1985)

Miss **Pinchuk**. And then you can see our money is going down. These two lines are not staying equal.

What is happening, then—we have a population that is having to become Welfare-dependent, and these are costs not to the Nation only, but obviously to the States.

What has happened—the Federal Government had been paying full, 100 percent reimbursement to the State and local governments such as Hawaii, California, Texas—there are dozens of States that have refugees settled in those States by the State Department.

But what is happening, HHS balances their budget by again pulling back and not fully reimbursing us. Now, for 1990, we have a further dismal picture, because once again, the State Department, wanting to increase refugee admissions, has acknowledged that they need money. But HHS again continues to decrease the amount of reimbursement that we have for both our welfare benefits and the services, and once again, my charts regretfully have lines that keep splitting.

As our admissions go up, our programs are going down. Refugees are a very courageous people, and they want to learn. They desperately want to learn our language, and be supporting. But when they do not have the opportunity, obviously they become depressed, they become dependent, and we do not want to see our new Americans have that confronting them. We want them to have a choice.

My last chart shows again our per capita. What is happening here again—through HHS—is to make things balance, they just keep cutting back on the services.

We feel, and I know you stated it earlier today, that the Federal policy for admissions is a Federal policy, and should not be borne by the State and local taxpayer, or, most sadly, by our refugees.

PREPARED STATEMENT

They again deserve better, and we hope that you will agree with us and raise our budget from what it has been in the past, to give us full reimbursement, which is roughly $150 million nationwide over our 1989 level. We are looking at roughly $500 million to give our new Americans a chance in this country, so they will be proud of them and we will be proud of them, too.

If you have any questions, I will be glad to answer them.

[The statement follows:]

STATEMENT OF JOAN PINCHUK

Mr. Chairman and members of the Subcommittee, I am Joan Pinchuk, Refugee Coordinator of Los Angeles County and Director of the Refugee Targeted Assistance and Employment Services Programs in Los Angeles for the Department of Community and Senior Citizens Services. I appear here today in support of a full 36 months funding as specified in the Refugee Act of 1980, including full restoration of Targeted Assistance and Employment Services. As the FY 1989 proposed admission level exceeds the FY 1989 budget and the FY 1990 forecast by 32,000 refugees, the federal government has an obligation to fully fund these additional admissions and help these refugees become productive members of our society. We recommend that FY 1990 Office of Refugee Resettlement (ORR) funding for State-administered programs, Targeted Assistance, and Preventive Health be increased to $516 million from the FY 1989 level of $366 million. This $150 million increase is needed in order to:

- Restore the 36 months of full federal reimbursement of State and local refugee cash and medical assistance costs authorized under the Refugee Act of 1980 instead of ORR's proposed reduction from 24 months of reimbursement to 15 months.

- Address the employment needs of the greater than anticipated number of refugees being admitted into the country.

We recognize that budgetary constraints exist, but we urge that Congress not take disproportionate cuts from this program and pass the burden of refugee costs onto State and local governments. Since 1983, the federal government has reduced funding by $203 million (or 35 percent) while refugee admissions were increased by 54,800 (or 89 percent).

IMPACT OF REFUGEE ADMISSIONS ON LOS ANGELES COUNTY

In recent years, refugee resettlement in Los Angeles County has grown to over one-fifth of the total refugee admissions into the United States. The cost of these refugees to the State of California and the County of Los Angeles has more than tripled since 1983. Increased refugee admissions into Los Angeles County, coupled with significant decreases in federal funding have shifted a large percentage of the costs onto the State of California and the County of Los Angeles.

For the current fiscal year, 50,300 refugees, or 70 percent of the 72,750 refugees receiving assistance in Los Angeles County do not qualify for full federal reimbursement. As a result, Los Angeles County's share of the cost of the refugee cash and medical assistance will be approximately $9 million. Any plans to reduce the time-eligibility period to 15 months would only further shift the burden of refugee assistance onto State and local governments.

These statistics do not consider the many refugees in need, but not receiving any assistance at all. If the federal government decides to admit refugees using the "parole" status (i.e., not eligible for fully funded federal assistance), an even greater number of refugees/parolees would not receive assistance. Los Angeles County and other local governments would be forced to absorb an even higher share of the refugee cost.

THE TARGETED ASSISTANCE/EMPLOYMENT PROGRAM ARE SUCCESSFUL

For the five years that Targeted Assistance has operated in Los Angeles County, the following results have been seen:

- The Refugee Targeted Assistance program has placed approximately 7900 refugees in unsubsidized employment.

- Over 500 poverty-level refugees obtained jobs, diverting them from the welfare rolls.

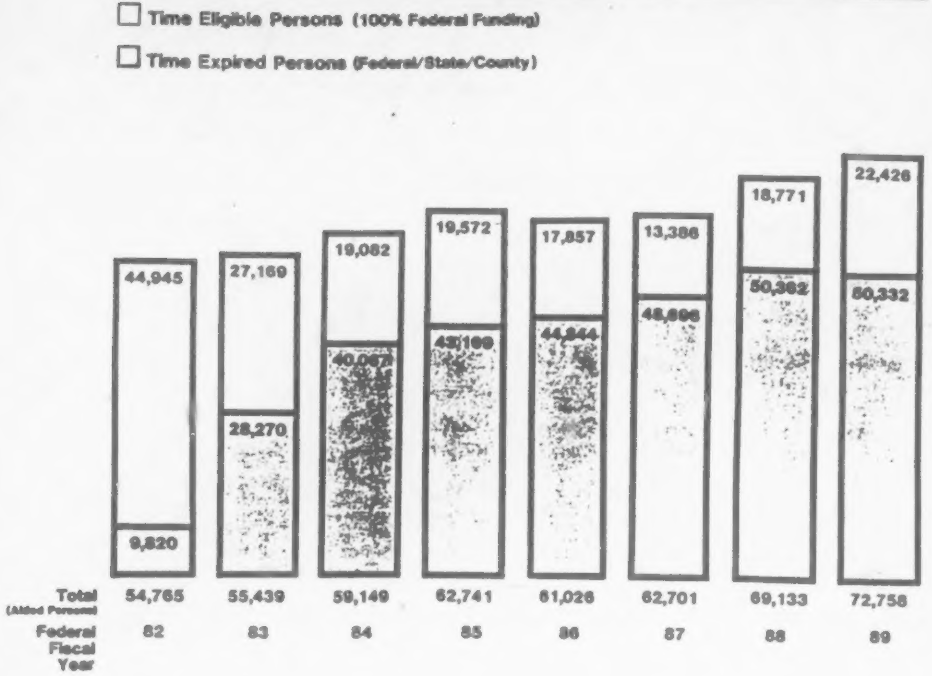
- Approximately 2700 welfare cases, affecting roughly 8300 refugees, had their grant reduced or terminated as a result of employment obtained through the targeted assistance program. In 1988 alone, targeted assistance placed refugees in jobs resulting in roughly $3 million in savings from reduced or terminated welfare payments.

The Targeted Assistance program has been successful in assisting refugees overcome barriers to employment which include inadequate English language skills, inadequate education, and, in many cases, large family size. The cost per refugee is $3500 compared to the annual cost of welfare benefits for a family of three which is $8000.

CONCLUSION

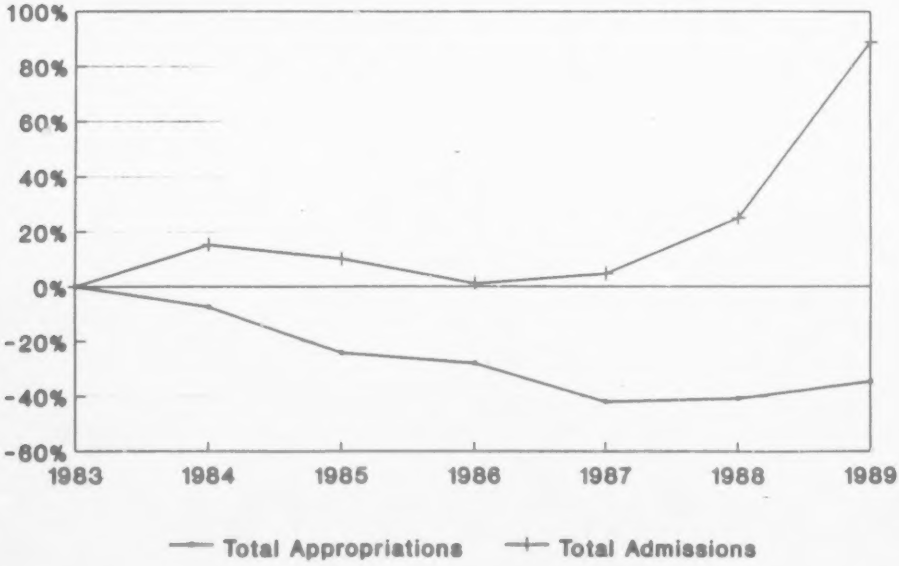
The federal government determines refugee policy and sets admission quotas. The federal government has an obligation to fully fund its program to help refugees avoid welfare dependency and become productive members of our society. Full funding for refugee cash, medical, and administration is needed to fulfill the objective of the Refugee Act of 1980 -- that is to help refugees adjust to their new living conditions. Also, the Targeted Assistance and Employment Services are needed to help refugees learn the English language, and to help them overcome other barriers to gainful employment.

County of Los Angeles Refugee Public Assistance

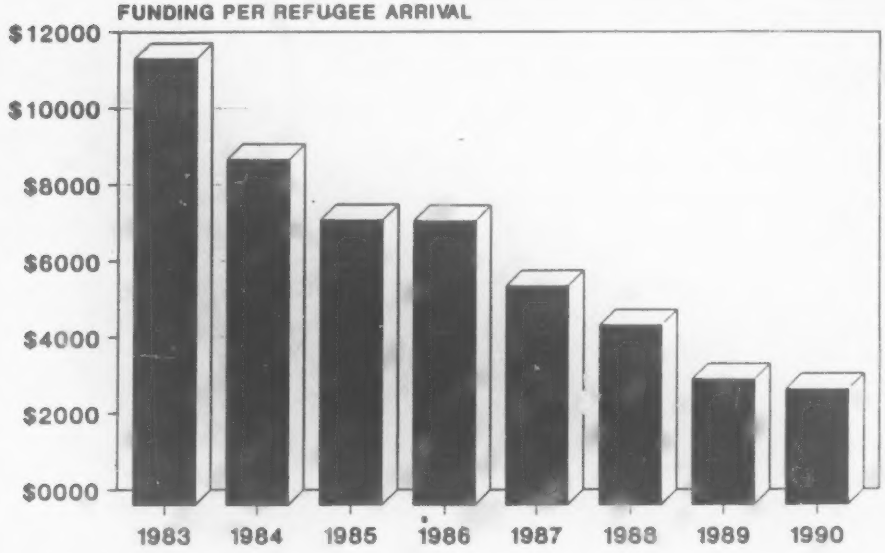


FEDERAL REFUGEE ASSISTANCE FUNDING

Percent Changes to Admissions/Funding



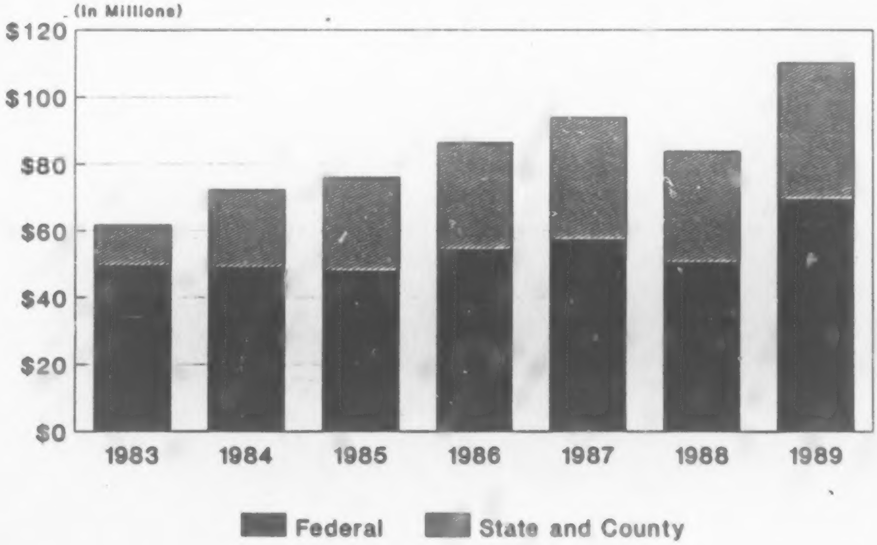
FEDERAL REFUGEE ASSISTANCE FUNDING PER REFUGEE ARRIVAL



In constant 1989 dollars, adjusted for changes in the Consumer Price Index

REFUGEE COSTS IN LOS ANGELES COUNTY

Costs are Shifted to the State & County



(Refugee & AFDC Assistance Payments Only
Excludes Admin. Costs & Indigent Aid)

Senator Inouye. I just want to concur with you fully, and point out that Los Angeles County and the State of Hawaii are the most favored destination areas for refugees.

If the United States is to adopt policies, they should be prepared to pay for them.

Mr. Ard. I could not agree with you more.

Senator Inouye. We are paying moneys to bring them in, but not to resettle them, and that is an important part. I do not think the burden should be borne solely by refugees and by the States and counties involved.

I want you to spend some time in Los Angeles, and you will find that Los Angeles is becoming a conglomerate of different villages. I recall, my last visit to Los Angeles, you had about 10 blocks of just Koreans?

Miss Pinchuk. Correct, right along Olympic Boulevard.

Senator Inouye. Olympic?

Miss Pinchuk. Yes.

Senator Inouye. Then, the whole city of Monterrey is now Chinese?

Miss Pinchuk. Yes.

Senator Inouye. And the same thing with Koreans and Vietnamese and Cambodians and Laotians?

Miss Pinchuk. Right.

Long Beach has the largest Cambodian population, you know, next to Cambodia. So we have many, many communities.

Senator Inouye. I can assure you that I will convey your message to my colleagues on the committee, and we will do our best.

Miss Pinchuk. Thank you very much. It is a pleasure.

Senator Inouye. Thank you, Miss Pinchuk.

SUBCOMMITTEE RECESS

With that, the subcommittee will now stand in recess until 9:30 a.m., Thursday, May 4. At that time, the subcommittee will continue public witness hearings on the administration's fiscal year 1990 budget request and the hearings will be held in room SD–116.

[Whereupon, at 12:45 p.m., Wednesday, May 3, the subcommittee was recessed, to reconvene at 9:30 a.m., Thursday, May 4.]

DEPARTMENTS OF LABOR, HEALTH AND HUMAN SERVICES, AND EDUCATION AND RELATED AGENCIES APPROPRIATIONS FOR FISCAL YEAR 1990

THURSDAY, MAY 4, 1989

U.S. Senate,
Subcommittee of the Committee on Appropriations,
Washington, DC.

The subcommittee met at 9:40 a.m., in room SD–116, Dirksen Senate Office Building, Hon. Tom Harkin (chairman) presiding.

Present: Senators Harkin, Burdick, and Cochran.

NONDEPARTMENTAL WITNESSES

Senator Harkin. The subcommittee will come to order.

This morning we continue with the second of 6 days of public witnesses' testimony focusing on programs funded by the subcommittee.

During these several sessions, the subcommittee will hear testimony from approximately 150 witnesses. It is a matter of regret to all the members of the subcommittee that we have had to limit the number of witnesses we are able to hear this year. You have all been very understanding about our time constraints, and we do want to assure you that witnesses who have their testimony to the subcommittee staff by May 15 will have that testimony put into the hearing record.

In order to help us stay on schedule we are going to use the red light/green light system. What is that all about? As you know, each witness has 3 minutes in which to present his or her own testimony. When the red light goes on, your 3 minutes have expired. We need to ask each of you to conclude your remarks when the red light goes on so that each witness will have a fair and equal opportunity to be heard.

STATEMENT OF DR. JANE GOODALL, THE JANE GOODALL INSTITUTE, TUCSON, AZ

Senator Harkin. I would first like to welcome all of you to the committee, and our first witness is Dr. Jane Goodall of the Jane Goodall Institute. Then we will hear from Christine Stevens of the Society for Animal Protection Legislation.

Dr. Goodall, it is always a pleasure to see you here. I enjoyed our visit in our office and the book you gave me, and, of course, I have been a great admirer of yours for a long time.

You know, I asked some questions of NIH the other day. They told me that they have been working with you and that they are moving ahead. I think they have assured me that they are moving ahead to ensure the sociability of the chimpanzees.

Dr. **Goodall**. They have not told me that.

Senator **Harkin**. They told me that yesterday. If you hear anything different, you let me know, OK?

Please proceed.

Dr. **Goodall**. Thank you, Mr. Chairman. I am here to testify on behalf of the Jane Goodall Institute, really to make a plea for our closest living relatives, creatures who differ from us domestically by only just over 1 percent. That is the difference in the DNA.

I have worked with them now for nearly 30 years in the wild, during which time we have discovered that there are these uncanny similarities in social behavior. There are long-term affectionate bonds between mothers and their offspring that continue throughout life. There are remarkable similarities in our nonverbal communication system, so the chimps, like we, greet by kissing, embracing, holding hands, patting one another on the back.

During these 30 years we have also found there are very striking similarities in cognitive abilities, so that chimpanzees can reason and solve simple problems, can have a concept of self. They understand and use abstract symbols in their communication. They have a sense of humor. They are capable of acts of altruism and, perhaps most important of all, they share emotions like joy and sorrow, rage, fear, pain, and despair. They are sentient, sapient beings.

PREPARED STATEMENT

Unfortunately, they are treated in biomedical research laboratories sometimes as mere machines. I have seen conditions where chimpanzees have been confined in cages 22 inches by 22 inches and 2 feet high. These are conditions in which we would not keep the most hardened criminals, and yet the chimpanzees, because they are so close to us, because they are genetically so close to us, are used in various kinds of infectious disease research. We are using them to try and better understand human suffering and illness, and it is a mockery of justice if we do not give them the conditions they deserve.

[Pause.]

I am sorry. I thought my light had come on, so I stopped.

[The statement follows:]

STATEMENT OF DR. JANE GOODALL

On December 1-3, 1987, a workshop on the psychological well-being of captive chimpanzees was held in order to compile the best scientific information on appropriate housing and maintenance for chimpanzees in laboratories and zoos. Attached for the use of the Subcommittee is the list of participants and the formal recommendations to the U. S. Department of Agriculture. I would emphasize briefly some of the key points from this report.

To begin with, a short summary of the nature of chimpanzees:

> Chimpanzees show many cognitive abilities once viewed as uniquely human. They are, for example, capable of reasoned thought, generalization, abstraction, symbolic representation, and self-awareness. Many of their emotions, such as joy and sadness, fear and anxiety, and even a sense of humor, are highly similar to ours. They also exhibit empathy and friendship, perform acts of true altruism, and mourn the deaths of companions. There are also many similarities in social behavior, including communicative gestures such as kissing, embracing and holding hands. Close, supportive, friendly bonds between individuals are maintained and strengthened, via social grooming and many other relaxed social activities, through spending long hours in one another's company. These relationships last for a lifespan of 40-50 years. Separation from a close companion can lead to marked distress, even among adults. Any youngster less than 5 years in age who loses a mother is likely to become clinically depressed and may even become so ill that

> death follows . . . It is precisely because chimpanzees are so like humans physiologically that they are used by medical researchers in the attempt to alleviate human suffering and illness. And it is also because they are so like ourselves emotionally, cognitively and behaviorally that we must improve the quality of their lives during those long years of imprisonment and servitude.

Under "General Issues," the report states:

> Scientists intending to perform experiments on chimpanzees must be able to prove, beyond all reasonable doubt, that the experimentation cannot be performed by using a lower species, via non-animal alternative methods, or through carefully controlled clinical research. Chimpanzees should only be used for laboratory research of exceptional importance.

Summarizing housing conditions:

> Chimpanzees must be kept in compatible groups, at a minimum two individuals together . . . The size of enclosures should increase on a sliding scale as a function of the number of chimpanzees being housed in a group. Two adult chimpanzees require 400 square feet of usable space, but in cases of demonstrated compatibility four adults or six juveniles can be maintained in enclosures of this size. If a scientist can confirm an empirical need for individual housing for experimental purposes, the enclosures must never be smaller than 196 square feet (14 ft. x 14 ft.) with as much height as is reasonably possible within a standard room (minimum 7 feet).

Social care factors are important:

> Infants must remain with their mothers as long as possible, at least to the age of 18 months . . . Youngsters of any age who are separated from their social groups for use in any experiment must be given a minimum period of 3 months for adjustment to their new conditions, before placement in any experimental situation. Careful attempts must be made to reunite juveniles and infants with their mothers in their original social group at the completion of experiments.

Under "Schedule of Implementation," the workshop stated:

> Temporary improvements to existing enclosures, such as joining tunnels and exercise rooms, must be implemented within one year. More extensive reconstruction or erection of new enclosures must occur within five years.

Matching funds should be available to institutions that meet the basic criteria to upgrade housing for chimpanzees and other primates. If the final regulations promulgated under the Improved Standards for Laboratory Animals amendments to the Animal Welfare Act are not equal to those recommended by the workshop, we urge this distinguished Subcommittee, nevertheless, to encourage the National Institutes of Health and its grantees to meet the higher standards. It is important, therefore, that the Subcommittee provide for, under the FY '90 appropriations, a special fund for this purpose.

Thank you for the opportunity to testify.

STATEMENT OF CHRISTINE STEVENS, SOCIETY FOR ANIMAL PROTECTIVE LEGISLATION

Senator **Harkin**. Did you have something to add, Christine? Do you have anything to add to this?

Ms. **Stevens**. I would like to add quite a few things about the whole situation. Would you like me to say something now?

Senator **Harkin**. You have another minute or two if you have something you would like me to know.

Ms. **Stevens**. Yes; basically, it is very important that the alternative which NIH should be developing under the Health Research Extension Act of 1985, we do not know at all whether those are being developed. It is impossible to get the information. We would like you to urge them to change their program announcement to request for applications. It sounds very technical, but if they did that we would know whether they actually are developing any alternatives in accordance with the law or not.

We would very much like also to have this subcommittee recommend appropriations to make that possible so that they actually have money, and then the scientists would come forward with good proposals. We do not know that this is happening at all.

Second, we would like you to appropriate funds on a matching basis for improvements in animal quarters that will have to be done under the improved standards for laboratory animals amendments to the Animal Welfare Act. That is extremely important, too.

PREPARED STATEMENT

Finally, we would like you to urge NIH to stop throwing obstacles in the way of finalization of these regulations because they have kept doing that.

So those are our three begging requests.

[The statement follows:]

STATEMENT OF CHRISTINE STEVENS

The Health Research Extension Act of 1985 (PL 99-158, Section 4) required the National Institutes of Health (NIH) to establish a plan for research into "methods of biomedical research (A) which do not require the use of animals, (B) which reduce the number of animals used in such research; or (C) which produce less pain and distress in such animals than methods currently in use." The plan was further required tc establish "validity and reliability of the methods", to develop them and to train scientists in their use.

In November 1986, when the "Research Plan for 'Alternatives' to Animal Use" plan was circulated throughout NIH, animal advocates were hopeful. The plan recognized that NIH had "no focused program to develop non-animal models for research". Unfortunately, that is still true.

In order to achieve such a focus the plan should have provided for a "Request for Applications" (RPA) rather than the mere "Program Announcement" (PA) which signals lack of serious commitment by NIH. No accounting or report has been provided by NIH on the results of the plan. The time has come to demand accountability and definite action.

We urge this distinguished subcommittee to take three actions to achieve the intent of Congress.

1) Recommend a specific, line item appropriation for FY90 for development of methods which do not use animals, use fewer animals, or reduce those animals' pain and distress.

2) Require accountability consonant with government responsibility on the use of the funds, including specific identification of each grant funded.

3) Strongly urge a change from the use of a "Program Announcement" (PA) to a "Request for Applications" (RPA). Under a "Program Announcement" it is virtually impossible to track the use of funds used for the purposes listed in Section 4 of the Health Research Extension Act. If this were changed to a "Request for

Applications" confusion would be eliminated and there would be a defined dollar amount. This, in turn, means that more high quality scientific effort would go into the grant proposals. The goal of developing alternatives would be hastened as intended by Congress and urged by the public. There would be no question of how the money was allocated and used.

4) Recommend that Biological Models and Materials Resource Section (BMMR) be charged with coordination of development of alternatives and that it be made independent of and separate from the Division of Research Resources' animal using activities. This would avoid the undesirable ambiguity that currently exists. Congress and the public expect development of alternatives as a specific goal. BMMR should be asked to make a detailed report available to the public.

The current system makes it impossible to ascertain the amount of public funds being used for development and use of alternatives. I use the word "alternatives" as short-hand for the three R's: Replacement, Reduction, and Refinement whose intent is reflected in the phraseology of Section 4 of the Health Research Extension Act, quoted above.

There is great public interest in alternatives that can prevent animal suffering while advancing scientific knowledge to benefit human health. Congress has recognized this interest, but implementation by the National Institutes of Health has been feeble to say the least.

Some animal experimenters have taken personal offense at the well-merited criticism levelled at unnecessary abuse and neglect of laboratory animals (for example, the documentation contained in the book published by the Animal Welfare Institute, Beyond the Laboratory Door). They dismiss the possibility of advancing the Section 4 goals.

This irrational bias should not influence sound decisions by the subcommittee. We urge you to recognize the major benefits to society that effective encouragement of alternatives can bring:

1) Prevention of needless and unproductive animal pain and distress.

2) Fulfillment of the strongly felt desire for such prevention by millions of Americans, as demonstrated by a wide variety of surveys.

3) Reduction in costs of testing, research, and education through reduction of numbers of animals currently being used in both government and the private sector.

4) Increase in accuracy in many aspects of the above. This is especially true of the most recent developments in testing. (See Benchmarks: Alternative Methods in Toxicology, edited by M. A. Mehlman, Princeton Scientific Publishing Co., Inc., 1989) A copy is herewith submitted for the use of the Subcommittee. Please note that this book was made possible by a modest grant by the National Agricultural Library under the Improved Standards for Laboratory Animals amendments to the Animal Welfare Act. This is a practical application of government funds to solution of the problems addressed by Section 4 of the Health Research Extension Act.

Surely the National Institutes of Health with far greater resources at its disposal should have something more to show for the funds appropriated for this purpose.

Funds for Care and Housing of Animals Used in Experiments

While reduction in numbers of animals used can free up funds to provide for adequate care and housing of those whose use continues, we believe some additional funds should be made available by the Congress to ensure humane animal maintenance.

Certain parts of the animal-using community asserts that improved standards for laboratory animals lessens funds available for research. These complaints need a practical response. We urge this subcommittee to recommend appropriation of matching funds to upgrade care and housing of experimental animals where necessary to comply with minimum standards under the 1985 amendments to the Animal Welfare Act.

Institutions which receive government grants for research should have the opportunity to obtain assistance in providing minimum standards of housing and care for animals used in that research. If they cannot or will not provide properly for the animals, the research should not be funded.

In appropriating funds for decent treatment, care and housing of experimental animals it is essential to recognize that a great deal of the needed improvements need not be expensive. The most important element is the will to see that animals are as comfortable and contented as possible. The attitude of all personnel who have contact with the animals from scientists to animal care givers is the most important of all.

Simple modifications of existing facilities or equipment, often answer the animals' needs without resorting to purchase of costly new cages. In seeking enactment of the Improved Standards for Laboratory Animals (ISLA) amendments to the Animal Welfare Act we aimed at a goal embodying what well-run animal quarters with compassionate personnel already do. The Animal Welfare Institute paperback Comfortable Quarters for Laboratory Animals, thousands of copies of which have been distributed free on request to hundreds of scientific institutions throughout the country, is illustrated with photographs from well-managed laboratories. I hope the subcommittee will recommend very careful planning to maximize attention to the behavioral needs of the different species of laboratory animals while minimizing the expenditure of funds to meet those needs. Provision of matching funds will help to focus administrators' minds on practical changes to comply with the ISLA regulations as soon as they become final. We will be happy to provide consultation on request from institutions who want advice.

In conclusion, I urge the subcommittee to make a strong recommendation of support and encouragement by NIH for prompt finalization of the regulations under the Improved Standards for Laboratory Animals amendments to the Animal Welfare Act. Foot-dragging and obstacle erection by NIH have already caused unconscionable delay in the implementation of the law due to take effect December, 1986.

It is the interest of all concerned that experimental animals be given the best possible care and treatment. Better science, better ethics, and public accountability all demand it. But selfish interests are fighting to block and weaken the proposed regulations. Please lend your great influence for good to put the law into effect for the benefit of the animals used to protect human health.

Senator HARKIN. We can certainly get that request in for the information. We can do that.

How much were you asking for the foundation, though?

Ms. STEVENS. We are not asking for any fixed sum of money because we do not know how much NIH—if they would tell us what they have done, we could have some basis for a rational request. We have none.

Senator HARKIN. I understand.

Ms. STEVENS. We are just out there swimming in the dark.

Senator HARKIN. So you want us to get that information?

Ms. STEVENS. Yes; please.

Senator HARKIN. Thank you very much, Dr. Goodall. I wish we had 2 hours, but we just do not. I appreciate your time and interest in what you are doing, and rest assured I raised that question with them the other day, and we will follow it up.

Thank you.

Ms. STEVENS. May I lease this for the use of the subcommittee? This is a very good piece of work that has been done under a grant from the National Agricultural Library which with very little money has at least accomplished something, an alternative that is actually happening.

Senator HARKIN. All right. Thank you very much, Ms. Stevens. Thank you, Dr. Goodall. Thank you very much.

Our next witness is Dr. Krim. I do not see Mathilde here.

Mr. STEIN. Mr. Chairman, I am Gary Stein from the American Foundation for AIDS Research. Dr. Krim has not yet arrived.

Senator HARKIN. All right, we will just go on.

Mr. STEIN. Thank you.

Senator HARKIN. Then we will put Dr. Krim in.

STATEMENT OF JEAN McGUIRE, EXECUTIVE DIRECTOR, AIDS ACTION COUNCIL

Senator HARKIN. Ms. Jean McGuire, executive director of the AIDS Action Council.

Ms. McGUIRE. Senator Harkin, I am Jean McGuire, executive director of the AIDS Action Council, the national public policy representative of AIDS service organizations around the country.

As you know, it has been these organizations that have been on the front lines of the epidemic, and it is these organizations whose interest I am representing as well as referencing the interest of the National Organizations Responding to AIDS, a very broad coalition here in Washington that represents the comprehensive concerns of the health, education, and other interest groups in the development of AIDS policies.

Your committee has received the NORA document which I urge you to review further in terms of our overall recommendations. The $2.1 billion that we are calling for in AIDS program dollars, including the FDA in that document, goes considerably beyond the $1.6 billion that the President recommended but is well within the framework of what the Public Health Service originally recommended this year before the OMB passback, and it also reflects what the Institute of Medicine has been calling for for a number of years now.

[The statement follows:]

STATEMENT OF JEAN McGUIRE

INTRODUCTION

The above signed members of the coalition National Organizations Responding to AIDS (NORA) join in urging $2.152 billion in spending for AIDS by the Department of Health and Human Services in fiscal year 1990. Of this, $2.081 is part of the Labor-HHS appropriation ($2.046 billion for PHS agencies excluding FDA and $35 million for non-PHS agencies) and $71 million is part of the Agriculture appropriation (FDA).

This request is approximately $452 million greater than the President's request for 1990, and nearly $852 million above current spending. This reflects needs for AIDS activities as determined by the agencies, and is in line with the continuing recommendations of the Institute of Medicine for $2 billion in spending on research and prevention by 1990. Nonetheless, even this higher level provides insufficient resources for a number of priority programs authorized by Congress last year in P.L. 100-607.

Increased spending is essential to meet the changing patterns of the epidemic as it expands demographically, posing new challenges in the prevention and services areas. In addition, as our progress in the research area continues, new avenues are opened for exploration, while some areas remain unexplored since the beginning of the epidemic.

In proposing this alternative plan for spending, we are all too aware of its deficiencies -- particularly in meeting the care needs of those with HIV disease. AIDS threatens to overwhelm the public hospital system in many communities, and our proposal does not begin to provide the level of assistance that is needed to care for those with AIDS and assure the system will be functioning for poor people who require care for a range of health needs.

In seeking this level of spending, we recognize that other biomedical research, care, and prevention programs are facing significant reductions in funding in the 1990 proposed budget. We join in opposing those cuts. We believe the nation's commitment to public health should not be selective and the budget-making process should not pit diseases against one another. While we believe that all efforts against disease will benefit from the experience and knowledge gained from the battle against AIDS, we also recognize that we could not have made the progress against HIV that we have without the basic research that predated this epidemic. We must find the resources to fund all these needs adequately.

Summary of NORA AIDS Recommendation for FY 1990 (in millions)

PHS AIDS Programs	2,046
Other	35
TOTAL LABOR/HHS REQUEST	2,081
[Total AIDS recommendation with FDA ($71 m)	2,152]

PHS-wide concerns and priorities

Agency	FY 89	FY90 (Pres.)	FY90 (NORA)
	(in millions)		
ADAMHA	175	218	289
CDC	382	474	584
HRSA	45	56	254
Indian HS		1	1
NIH	607	753	900
OASH	13	41	18
Total PHS AIDS Programs in Labor/HHS	1,222	1,543	2,046

Our highest priorities for expansion of federal efforts in the fight against AIDS in 1990 are increased support for care for persons affected by HIV (ranging from direct primary care for low income individuals to mental health services for those infected with HIV) and wider efforts to prevent the spread of HIV infection through community-based, targeted activities (ranging from expanded access to drug abuse treatment to behavior change counseling and education to prevent sexual transmission of HIV). Our progress in research is meaningless unless we assure access to those treatments for all Americans, not just those wealthy enough to afford them. Our hope for reducing care costs in the long-term are directly related to our willingness to invest in prevention programs -- the only vaccine against HIV we will have for some time.

We continue to be concerned about the level of research activity into treatments and a cure for HIV-related disease. As the number of potential therapies increases, we must be certain that the NIH has sufficient resources to expand its capacity to test those drugs. Funds, staffing, and space should no longer be the excuse for delays in getting promising therapies into the clinical trial system. We are particularly excited by the potential of the NIAID's new community-based clinical trial efforts, as authorized in P.L. 100-607, and believe it merits a higher level of funding than anticipated by the President's budget and the NIH request.

We are distressed at the continuing problems NIH has experienced in receiving the FTEs intended by Congress in the appropriations bills. The 1989 conference report noted that if agencies continued to receive additional responsibilities without the intended staffing levels, the Congress would need to reevaluate its reluctance to legislate FTE levels. We believe that last year's experience provides further evidence for Congress to specify FTE levels in the appropriations bill directly.

The President's budget does project a higher level of FTEs for AIDS. However, those increased levels are often at the expense of other important public health programs. The CDC, NIH, and HRSA have all received increased AIDS FTEs, but, overall, the agencies experience either a net loss of FTEs over 1989 or their increase in 1990 is not sufficient to cover the AIDS increases.

AIDS FTEs 1989-1990

Agency	1989 AIDS (Congress)	1989 AIDS (Actual)	1989 Total	1990 AIDS	1990 Total
CDC	523	523	4,496	635	4,570
HRSA	25	25	2,069	50	1,926
NIH	830	780	13,252	887	13,214

There are several general requests made by the Department regarding the handling of the AIDS account that we oppose. We believe that the funds for 1990 should not remain available until expended. We believe there are enough worthy projects ready to move that all funds can be obligated in the fiscal year.

We oppose a blanket reprogramming authority of up to 3 percent of non-AIDS budgets. The Congress has never been an impediment to speedy review of reprogramming requests and we believe Congress should have the right to review the source of funds when reprogramming is necessary.

Because Congress has always supported emergency reprogramming requests, we believe the contingency fund is unnecessary and instead should be moved into expansion of primary care services for persons with HIV. This is an area where a real emergency is already before us in many communities.

Finally, we oppose the consolidated account for AIDS funding in the Office of the Assistant Secretary. Through the original budget-making process, the Assistant Secretary has ample opportunity to shape the budgets and programs of the individual agencies within the PHS. To require a second round of justifications only adds an unnecessary level of bureaucracy and source of delay.

ALCOHOL, DRUG ABUSE AND MENTAL HEALTH ADMINISTRATION

1990 NORA Recommendation:	$289,000,000
1990 President's Request:	$217,603,000
1989 Budget:	$174,052,000

(Note: NORA's recommendation includes a $50 million transfer of funds from CDC to ADAMHA, assuming that NIDA would take the lead in AIDS prevention among drug abusers, rather than the CDC as indicated in the President's budget.)

We urge that the Congress direct ADAMHA to prioritize its efforts towards drug abuse issues and HIV prevention, and provide funds accordingly. These are the critical prevention issues identified by the National Research Council in its recent report. We are concerned that the growth rates identified by ADAMHA for 1990 do not reflect similar priorities. (ADAMHA projects only a 17 percent increase in IVDU-related efforts as compared to a 46 percent increase in neuroscience and behavior research.) We also believe that the relationship of AIDS and other sexually transmitted diseases to substance abuse generally requires more attention and should not be limited to intravenous drug abuse.

NORA recommends that $50 million be added to the ADAMHA budget to support HIV prevention activities among substance abusers, including intravenous drug abusers. As discussed in the CDC section, there is continuing confusion as to which agency -- NIDA or the CDC -- should take the lead in this area. The President's budget gives these responsibilities to the CDC. While we believe there is a need for strong coordination of prevention activities, NIDA's expertise regarding drug abuse argues in favor of retaining these activities at NIDA. This was a policy position taken by Assistant Secretary for Health Windom but not reflected in this budget request.

We are concerned that NIDA is moving away from direct participation in the AIDS prevention and drug treatment area. NIDA's outreach demonstration programs for drug abusers are being phased out in the President's budget. As the National Research Council and others have indicated, we are far from having a definitive model for effective prevention among drug abusers. It would seem that, rather than decreasing funding for these programs by $10 million, we should be increasing our efforts. Similarly, NIDA is moving to end treatment services. This is contradictory to the President's AIDS Commission's recommendation that we offer treatment on demand for IVDUs as part of an AIDS prevention program.

We support funding for the model mental health care demonstration programs, authorized at $10 million in P.L. 100-607, which would begin to develop models for the wide range of mental health services and care needed by people who are HIV positive and their families and caregivers.

Consistent with the recommendations of the National Research Council, we **recommend that research demonstration programs be funded to explore the efficacy of free needles and needle exchange programs in prevention of transmission of HIV among IV drug users.**

All HIV prevention efforts targeted to IV drug users should assure collaboration among local governments and community organizations otherwise meeting the care and treatment needs of this population.

Among other areas of research we believe worthy of new or additional funds are:

--> Research into AIDS **prevention among adolescents.**

--> **Randomized field trials of different prevention strategies,** as recommended by the National Research Council, to more systematically and scientifically assess the varied approaches to AIDS prevention now being used.

--> Research into **the role of substance abuse in disease progression** (as opposed to initial infection with HIV).

--> Research into the **social ramifications of the AIDS epidemic, including discrimination, stigmatization, and social pathology.**

We also recommend expansion of the research training program to increase the number of social and behavioral scientists consistent with P.L. 100-607. In addition, training of clinical providers is a vital need. As the number of persons with HIV increases, it is necessary to increase the number of substance abuse and mental health professionals, such as psychologists, psychiatrists, social workers, marriage and family therapists, counselors, and other appropriately trained professionals who are trained to handle HIV-related issues. Increased attention should also be focused on expanding the ranks of peer counselors who meet unique needs in the area of psychosocial support and substance abuse counseling.

CENTERS FOR DISEASE CONTROL

1990 NORA Recommendation:	$584,000,000
1990 President's Request:	$474,022,000
1989 Budget:	$379,152,000

We support the program initiatives contained in the President's budget request for AIDS prevention and control activities at the CDC. We would like to make special note of several items:

--> Continuation and expansion of the family of surveys is important to our understanding of the epidemiology of AIDS. We believe the Congress acted correctly in defunding the national household survey until tests of its practicality are completed. We continue to believe that the family of surveys will give policymakers the needed data on trends, which is more useful than the snapshot a household survey could provide.

--> We favor increases for more timely and complete case reporting, which is also important to our understanding of trends in the epidemic.

--> We strongly support the high-risk behavior and attitude survey. As the National Research Council recently reported, our knowledge in this area is so limited that we are not able to influence behavior change as effectively as we must to control this epidemic. We recommend report language that makes clear that this should be in conjunction with the work being done at NICHD in this area.

--> We support the dedication of funds for evaluation of behavior change methods. We have progressed enough in our approaches that it is time to assure quality evaluation. Report language should indicate the need for high quality evaluations to be included in the design of prevention programs and behavior change projects. To expand its linkage with the behavioral and social scientists with long-standing expertise in evaluation, CDC should establish closer links with the ADAMHA research agencies.

--> We support the mortality studies, authorized in P.L. 100-607, as important in helping us understand different aspects of the epidemic and target resources to make for a more equitable approach to AIDS care and services.

We recommend an additional $50 million be spent on prevention activities among substance abusers, with special emphasis on intravenous drug abuse. This is a population where the epidemic is growing rapidly and there is no systematic federal effort at prevention. In addition, the use of crack cocaine is an important factor in the recent rise in syphilis cases which is, in turn, a factor in the spread of AIDS. Indeed, efforts in this area resemble federal prevention efforts among homosexually active men four or five years ago. We further recommend that **these activities occur under the auspices of** NIDA, since they have the most experience in working with this population. There is some confusion within the PHS regarding who has lead responsibility in this area. While funds for IVDU prevention are included in the CDC budget, the Assistant Secretary for Health ordered that the CDC not enter this area in an earlier ruling. Some resolution of this conflict is needed before funds can be spent effectively.

We urge that an additional $45 million be directed specifically to support the prevention activities of community-based organizations. These organizations remain the lynch-pin of our nation's AIDS prevention activities. They are best able to address the specific needs of local populations. Few are recipients of direct federal funding and too few states and local governments pass on their federal funds to community-based groups. We recommend report language that directs the CDC to take into account geographic diversity as well as absolute incidence as a basis for distributing targeted funds. Some communities, with high per capita rates of AIDS but small in overall population have been frozen out of the federal funding programs. We also encourage the requirement of CDC to develop guidelines for AIDS prevention education programs in concert with the directives of the language contained in P.L. 100-607.

We also urge report language directing that funding of AIDS prevention programs for minority populations be targeted towards those groups with experience working with the populations at risk, and that technical assistance be provided to these groups so they can successfully compete for federal grants and contracts. We are concerned that federal funds will go to groups with experience in competing for federal funds -- but without the experience of working directly with those populations (e.g., minority homosexual men, drug abusers, etc.) for whom the programs are intended.

We also urge report language directing the CDC to issue updated guidelines for development of AIDS educational materials. In the FY 1989 appropriations bill and in P.L. 100-607, Congress revised an earlier amendment and provided that AIDS educational materials could not be designed to promote or encourage illegal drug use or sexual activity. The new amendment was specifically designed to prevent a "chilling effect" on the development of innovative and targeted AIDS educational materials which had been feared as a result of the earlier amendment to the FY 1988 appropriations bill. Although guidelines currently being used by the CDC incorporate the language of the FY 1989 appropriations bill, they still do not adequately clarify the range of materials that would be acceptable under the revised provision.

We recommend an additional $50 million be appropriated for counseling and testing services, above the $119 million included in the Administration's request. P.L. 100-607 authorizes $100 million in spending for anonymous counseling and testing. We recommend that the Committees direct that the 1990 testing funds be split evenly between anonymous and confidential testing. We urge that the Committees again include language emphasizing that the value of testing is the counseling associated with it. We would further request that the proposed evaluation of the impact of counseling and testing on the nation's health, as included in the CDC request, study the relative impact on behavior change of counseling alone versus counseling with testing. As the recent National Research Council report noted, we still do not have definitive data in this critical area.

It should be noted that testing is no longer just a potential tool for behavior change. It is also increasingly used for medical evaluation. If an individual tests positive, it is wise to monitor more closely the individual's immune system. This kind of follow-up testing, sometimes resulting in medical interventions (e.g., prescription of AZT or the use of aerosolized pentamidine) raises questions as to the responsibility of public health programs to fund such testing and treatment. The Committees should direct the CDC to study the potential implications of such broader services.

The National AIDS Hotline plays an important role in educating the general public. It now has a capacity to serve Spanish-speaking and hearing-impaired callers. We believe that all necessary funds should be provided to this program.

We recommend an additional $15 million for paid advertising, as authorized in P.L. 100-607, to supplement the current voluntary program of public service announcements. The ability of the federal government to control placement of PSAs and their content is severely limited by the voluntary compliance that is needed from the networks. This money would permit **a study of the relative effectiveness of paid versus voluntary advertising.**

While not part of the AIDS budget, **we support an increase to $173 million for STD prevention and control** from the Administration's level funding of $78 million. The prevention and control of sexually transmitted diseases is directly related to the course of the AIDS epidemic. The behavior changes that can prevent the spread of STDs are the same that will prevent sexual transmission of HIV. This linkage is made more compelling by the role of STDs as cofactors in transmission of HIV. This substantial increase, requested of the Department by the PHS, is necessary to address the alarming increase in formerly controlled STDs among heterosexuals, which could portend dramatic increases in HIV transmission as well.

HEALTH RESOURCES AND SERVICES ADMINISTRATION

1990 NORA Recommendation:	$254,000,000
1990 President's Request:	$56,424,000
1989 Budget:	$55,131,000

(Note: The $254 million recommendation includes the $154 million originally requested by HRSA and the $25 million we would transfer from the proposed contingency fund.)

It is our belief that the area of the AIDS epidemic most neglected by the federal government is that of assistance to those agencies that provide health care to low income individuals. NORA, therefore, recommends **an additional $89 million to increase access to AIDS care services**, particularly for low income individuals. This would be in addition to the sorely needed (and still insufficient) $11 million requested by HRSA for AIDS treatment services by community and migrant health centers, to help offset the cost of the higher intensity of care required for HIV patients. This amount does not fully address the need at community/migrant health centers and it also does not reach into populations in need not served by the community health centers. Included in our $89 million expansion, therefore, would also be impact aid ($40 million) for public hospitals or other community based primary care providers, including local public health care facilities, for services that would otherwise be provided in a hospital setting in high-incidence communities. In many of these communities, the overwhelming burden of AIDS threatens to limit access and quality of care not just for persons with AIDS but all poor people relying on those institutions for their primary care. We support sufficient funds for continuation and expansion of the demonstration care programs. We also urge funding for the subacute care demonstration programs and early intervention programs created in P.L. 100-607 (which are authorized at $10 million each). We recommend report language directing HRSA to coordinate its low-income primary care assistance with efforts by the NIAID to attract a demographically more diverse population to its clinical trials programs. We also urge the continuation and expansion of targeted health care delivery planning efforts begun last year.

We recommend expansion of the pediatric care demonstration program by $16 million (from the current $8 million), rather than the level funding proposed in the

Administration's budget. This is one of the largest growing populations affected by AIDS and poses special challenges in providing appropriate care.

We recommend $30 million for continuation of the federal program to pay for life-extending drugs for persons with HIV-related disease. This program has been critical for extending access to AZT for thousands of persons with AIDS. While set to expire in March, new authorization is anticipated before the new fiscal year that would move the program toward a federal-state match. As the number of people with AIDS increases, and as the number of people recommended to take AZT and other expensive therapies increases, the need for this program will grow.

We support an additional $50 million to fund the newly authorized home health care program (under P.L. 100-607). This program would assure access to home health care for thousands of persons with AIDS, ultimately saving the federal government money in reduced hospitalization costs for Medicaid patients.

We urge expansion of the capacity of the Education and Training Centers by $3 million, rather than the level funding recommended by the Administration. ETCs currently provide training for physicians and nurses; we believe the ETCs' mandate should be expanded to include all care givers for persons with HIV infection.

We recommend $10 million for legal advocacy services for persons with HIV infection. The legal problems facing persons with HIV are extensive and unusual. Their ability to access care and services necessary for their health is often related to their ability to access legal assistance to assure those services.

NATIONAL INSTITUTES OF HEALTH

1990 NORA Recommendation:	$900,000,000
1990 President's Request:	$752,670,000
1989 Budget:	$603,799,000

We are concerned that the NIH budget, as presented by the President, does not provide sufficient funds for taking advantage of the progress already made in AIDS research. Without more funds and more staff, we believe it will be impossible for the NIH to meet its commitment to expand the number of drugs in clinical trials and explore new areas that have been opened up by earlier AIDS research. Among the deficiencies that cut across institutes at the NIH are:

--> **The institutes need additional FTEs.** The NIH requested 1123 and received 887, a very significant differential. These AIDS FTEs should be new FTEs and not taken from other programs.

--> **The President's budget is $95 million short of the agency's request for extramural grants** -- investigator-initiated and targeted grant programs as well as basic research centers. These are the backbone of all research at NIH and are areas that the Presidential AIDS Commission and the Institute of Medicine, among others, have consistently identified as in need of significant expansion.

--> The growth in R&D contracts is minimal. (The current services level is $194 million, the budget request is $206 million, and NIH requested $237 million.) **We recommend additional funding for contracts as well as report language recognizing the importance of contracts in carrying out NIH-directed AIDS research.** This mechanism is important to accomplishing such programs as the community based clinical trials and assuring a standard reagent supply for researchers around the country.

--> **We recommend an increase in the number of training slots for NIH,** as opposed to the decrease recommended in the President's budget. Attracting more scientists to AIDS research is critical to our progress. Every mechanism must be used, including research training posts and more innovative approaches such as the loan repayment program being initiated for those entering AIDS research.

--> We are concerned that insufficient resources have been given the institutes for technological advancements to enhance research efforts.

We support the increased spending in the President's budget for pediatric AIDS activities (from $50.3 million to $63 million), **but would add an additional $7 million to NICHD's pediatric efforts** to bring its funding to the $35 million requested of the Administration by NIH. The recent hearings held by the House Human Resources and

Intergovernmental Operations Subcommittee made clear that considerably more effort is needed in the pediatric AIDS area.

We also support the expansion of outpatient capacity for NCI and NIAID at the clinical center and urge that sufficient funds be approved to meet the doubling of capacity requirement in P.L. 100-607, as well as construction funds needed by the institutes to improve their capacity.

There continues to be growing evidence that behavioral and social factors influence the course of the epidemic and the progression of the disease. **We urge report language that directs the NIH to make behavioral research an integral part of its activities** -- from studies of self-deferral at blood banks by NHLBI, to NICHD's study of sexual behavior and practices, to quality of life determinants and issues of accrual of patients in NIAID's clinical trials, to enhancement of behavioral issues in the NIAID's multi-center cohort studies.

There are programs at specific NIH institutes that we believe require additional funds beyond the President's request:

--> **We urge significant expansion, beyond NIH-anticipated levels, of the NIAID community based clinical trials program,** which was originally funded in fiscal year 1989 and authorized in P.L. 100-607. This program is an important vehicle for spreading the geographic and demographic reach of AIDS research throughout the country and to allow more scientific study of a variety of treatments already being used at the community level. This program has received a tremendous response from community physicians and will only be able to fund a fraction of the programs eligible if the anticipated $12 million budget in 1990 is not increased. We recommend a doubling of this capacity to $24 million in 1990.

--> **We support increased funding to expand minority access to clinical trials** funded by NIAID ($21.23 million in the NIH request). AIDS is a disease that disproportionately affects minorities, yet the clinical trials program has not been successful in attracting minority participants. Funds are needed to help rectify this imbalance in access to trials -- the only serious hope we have to offer persons with AIDS at this time. We similarly **support increased funds to assure geographic expansion of the clinical trials program,** whether through expansion of the number of AIDS Clinical Trial Groups or through the community based trials program. (The NIH requested $10.5 million in this area.)

--> **We support expanded funding for the NIAID's ACTGs** to allow them to better meet the costs of AIDS patients and allow for expansion of the number of participants and drugs being investigated. We urge the inclusion of both primary care providers and consumers in the design of protocols conducted by the ACTGs and request report language directing the NIH to assure that when data from these trials is promising, that the earliest advantage possible is taken of the treatment IND process, as directed in P.L. 100-607.

--> **We urge that sufficient funds are granted DRR** so that the ACTGs will have the resources to provide adequate care for their clinical trial participants. The ability or willingness of the ACTGs to take on different types of patients is related to their ability to meet the costs associated with them. Efforts in this area may help resolve some of the demographic disparities currently evident in clinical trial participation.

--> **We urge full funding of two NCNR programs,** absent from the President's budget but in the original NIH request, **for career development awards to attract experienced nurse scientists to AIDS** ($180,000 for AIDS, $500,000 overall), **and for a clinical trial on optimal nursing care methods** ($1 million). Nurses remain the backbone of AIDS treatment. Every effort possible must be made to attract more nurses to this work and improve the care they provide.

--> **We urge report language stating Congressional support for the NICHD's sexual behavior study.** Understanding of current sexual practices is vital to our ability to undertake AIDS prevention activities and target messages.

Though not part of the AIDS budget, we are also supportive of expanded research into sexually transmitted diseases -- both in terms of their role as risk factors in HIV and as a public health crisis apart from AIDS. Behavioral research, epidemiologic studies, and prevention research should be expanded with special emphasis on the importance of drug use in the STD epidemic. Programs within the new STD Branch of NIAID and studies at NICHD need additional staff and resources.

The NORA coalition also supports research at the NIH into Chronic Fatigue Syndrome. A growing number of individuals are suffering from the syndrome, the cause and treatment of which remain a mystery. Knowledge gained in this area could well be of benefit to AIDS research as well.

OFFICE OF THE ASSISTANT SECRETARY FOR HEALTH

1990 NORA Recommendation:	$18,000,000
1990 President's Request:	$41,000,000
1989 Budget:	$13,000,000

As mentioned above, we oppose the contingency fund of $25 million and have redistributed those funds as part of our recommendation. The Congress has consistently approved additional funds or reprogramming to meet emergency situations without inordinate delay, thus obviating the need for this kind of reserve fund. We believe that there are already insufficient resources to meet many emergency situations associated with the AIDS epidemic that speak for immediate distribution of these funds.

We support the funding for the Office of Minority Health, and we hope there will be cooperation and coordination between the activities of the OMH and the newly authorized minority prevention office at the CDC.

We strongly support the care cost studies as critical to our understanding of the health care financing implications of this epidemic. It is this area that threatens our nation's fiscal health as well as the viability of our health care delivery system. These studies are welcome, if long overdue.

We recommend earmarking an additional $2 million for the work of the National AIDS Commission, which should be fully staffed by the beginning of the new fiscal year.

OFFICE OF FAMILY PLANNING

We support $10 million for comprehensive risk reduction programs at Title X clinics to reduce perinatal and sexual transmission of HIV and other sexually transmitted diseases. Funding for this approach was sought by the Office of Family Planning but rejected by the OMB. We believe every opportunity to access populations at risk through existing programs should be used.

OTHER PROGRAMS

OFFICE OF HUMAN DEVELOPMENT SERVICES

We support the recommendations of the Pediatric AIDS Coalition for $20 million in funding for the Abandoned Infants Assistance Act. There is a pervasive lack of foster care and community placement for children with HIV infection. These funds would only begin to address a growing and tragic problem.

We also support $5 million for the Transitional Living Grant Program authorized under the Runaway and Homeless Youth Act for homeless youth between ages 16 and 20 who have no possibility of living with a relative in a safe environment or who have no available safe alternative living environment.

OFFICE FOR CIVIL RIGHTS

We support full funding for the Office for Civil Rights. This office has responsibility for enforcement of Section 504 of the Rehabilitation Act of 1973 among entities receiving funds through the Department of Health and Human Services. These entities include numerous hospitals, social service providers and other health care providers. Effective enforcement of Section 504 is critical for ensuring nondiscrimination protection for people with HIV disease. We also urge report language directing OCR to strengthen and increase its enforcement of Section 504 claims.

Senator **Harkin**. If I could just ask you, $2.1 billion?

Ms. **McGuire**. It is actually $2.052 billion, rounded up.

Senator **Harkin**. What would you use that for?

Ms. **McGuire**. Our primary increases are in the care area. Your committee has been very good——

Senator **Harkin**. Do you think we are doing enough in research?

Ms. **McGuire**. There is probably never enough to be done in the area of research, and we have some recommendations.

Senator **Harkin**. My understanding is that they just cannot do any more. We have loaded this thing up. We have gone from $5 million in 1982 to $1.6 billion next year, and that is quite an increase.

Ms. **McGuire**. Yes; it is quite an increase. I think there are some areas of research that are clearly going to be in need of expansion, and they include things like the community research initiative which will finally bring some research activities to rural areas and to underrepresented groups.

Clearly, one of the things that has not been addressed at all in the context of the appropriations process for the next several years is the increasing burden of care that we are feeling not just in high incidence areas like New York, San Francisco, Los Angeles, and Miami, but also in second and third wave cities in the middle of the country where they are smaller numbers but their relative higher incidence rate means that their systems are being impacted in a relatively difficult manner. We need to do something to provide infrastructure and support to those health care systems.

So our primary increases are focused around health care issues in the context of HRSA, expanding the demonstration grants that this committee was very good about giving a lot of leadership to. The planning money that you spearheaded last year for those second and third wave cities needs to also be extended, and efforts that will focus on some type of impact that will reflect the disproportionate impact of the incidence on different areas.

So I think in that context when you look at our number, what is different about that number is the recommendations for considerable expansion and care.

Senator **Harkin**. Yes; go ahead.

Ms. **McGuire**. You can read through the specifics, and I am sure your staff already has in the course of our document.

I think the other notation I would make is that the increased emphasis on resources going to community-based organizations and prevention efforts must be continued. Last year, there were some limitations by virtue of how the funding distribution worked that disadvantaged some of our rural and lower incidence areas that we would like to see fixed in the course of the appropriations of those dollars this year. That is something I am sure we can work out with the staff.

Senator **Harkin**. Thank you very much.

STATEMENT OF MATHILDE KRIM, Ph.D., FOUNDING CO-CHAIR, AMERICAN FOUNDATION FOR AIDS RESEARCH

ACCOMPANIED BY GARY STEIN

Senator **Harkin**. Dr. Krim is here.

Dr. Krim, do you need a little bit of time to get gathered?

[Pause.]

Mathilde, how are you? It is good to see you again.

You have someone with you?

Dr. **Krim**. Yes; this is Gary Stein.

Senator **Harkin**. Dr. Krim, welcome to the subcommittee. You were not here when I opened, and I have to apologize because we have 150 witnesses.

Dr. **Krim**. There is very, very little time.

Senator **Harkin**. Very little time.

Dr. **Krim**. I apologize for being late. I could not get on my airplane this morning. I came in from New York.

Senator **Harkin**. No problem, but I do appreciate your being here, and I also appreciate your talking to me in the past about this issue. As you know, I have a great interest in it.

Dr. **Krim**. Thank you.

Senator **Harkin**. Your testimony will be made a part of the record.

Dr. **Krim**. Yes; and I am going to read just a few quick notes. I am not going to read the whole testimony.

Mr. Chairman and members of the committee, as I said, my written testimony has been submitted to you. It requests that the Senate appropriate $450 million for AIDS funding alone in addition to the President's request.

I would like to state most emphatically for the record that this recommendation made on behalf of the American Foundation for AIDS Research still stands. It is indeed our well-considered opinion that the proposed increases in funding for national health programs, those programs that protect our most precious natural resource, our health, are woefully inadequate to address the challenges we face and that this is particularly so in the case of AIDS.

AIDS is a venereal disease caused by a blood borne infectious agent. Being a venereal disease, it is preventable. We have known this since 1982. We also knew by then that AIDS was not necessarily linked to sex, to sexual orientation, to age, to race, or to economic status. We knew, therefore, that everyone was potentially at risk for AIDS.

We should have said so loud and clear, but we did not. In fact, we did very little about AIDS and nothing at all until 1986 in the area of public education. As a result, we missed an opportunity to contain the epidemic. For several years, all we did was count cases, and those more than doubled each year.

In 1983–84, a French scientist first and then an American scientist discovered that AIDS was due to a very peculiar virus, a slow acting retrovirus now called human immuno deficiency virus, or HIV.

Starting in 1985, we had an antibody test to diagnose infection with this virus. I stress infection with and not just exposure to HIV. With this test, we could find out who is infected with the virus and who is not even in the absence of clinical signs of disease.

We found that many more people had been infected and had the disease. We hoped, however, that most people would resist the infection and remain well, as is often the case with other infectious diseases. In subsequent years, we found that all those infected eventually developed AIDS and that AIDS is in its natural course 100 percent fatal. We have not yet been able to change these terrible morbidity and mortality rates, and they are very highly unusual.

Cancer and heart disease still kill more people than AIDS in this country, but AIDS, unlike them, is rapidly spreading, and it is out of control. It mercilessly kills young adults and their babies. AIDS has already destroyed many more young American lives through death and disease than were lost in the Vietnam war. Well over 1.5 million Americans are now infected with the AIDS virus and all will die with AIDS within a few years unless effective and inexpensive treatments are rapidly discovered and made accessible to all those who need them.

Today there are in the United States at least 40,000 people with full-blown AIDS. There will be 200,000 of them by 1991 within only 2 short years. Most will be totally dependent for being ill and insured and impoverished. By 1991, the cost of that treatment alone will be $3.5 billion, and incapacitating or death of these people will cost this country $60 billion in lost productivity because most of them will be at the prime of their life in what would otherwise be their most productive years.

Our whole society is bound to experience a catastrophe because of AIDS. We will see a breakdown of our health care delivery system with a significant deterioration in general access to good medical care. Because of terrible suffering and fear, our civil liberties will be attacked and will erode. Grave economic problems will ensue, particularly for areas of high AIDS prevalence such as our urban centers.

New York City is already experiencing the first wave of the impending calamity that will no doubt spread across the country.

Despite the fact that we are going to continue in the foreseeable future to see more death among gay men because of AIDS, AIDS is slowly becoming a heterosexual disease. Last year almost one-half of all new cases of AIDS were diagnosed among heterosexual people. Yes; many of them had acquired the infection through dirty needles because of the injection of illegal drugs, but when they acquired the infection they started transmitting it sexually to others, most often women among whom one-third were not drug users and children, one-half of whom were born infected and doomed.

It has been estimated that in 2 years we can expect to have 73,000 American children orphaned by AIDS, one-half of whom will themselves be sick with AIDS.

I know of the burden felt by legislators at this time of fiscal shortages. However, most budget considerations are not a matter of life and death. AIDS is not a matter of life and death for just a few, for only junkies, but for all of our children and grandchildren.

PREPARED STATEMENT

As we talk, this virus is still marching on, silent, invisible, and uncontrolled. Stopping it must be truly our No. 1 national priority. The recommendations we are making are fully in keeping with those of the President's Commission on HIV Infection and those of the Institute of Medicine.

[The statement follows:]

STATEMENT OF MATHILDE KRIM

I am Mathilde Krim, Ph.D., research biologist and Founding Co-Chair of the American Foundation for AIDS Research (AmFAR). AmFAR is a not-for-profit national organization supporting biomedical and psycho-social research on AIDS. It also supports the development of educational programs and of rational public policy approaches to the control of the epidemic, with the purpose of helping to curtail its spread. Created in 1985, AmFAR has become the nation's leader in private-sector funding for AIDS research, having awarded a total of $16 million to over 270 carefully selected, promising research and development projects.

The whole world now faces an unprecedented health crisis. In this country alone, AIDS has already destroyed more lives, through death and disease, than the Vietnam War, and more than 1.5 million Americans have become infected with the Human Immunodeficiency virus (HIV). Because of the relentlessly progressive nature of this infection, all HIV-infected persons can be expected to die of AIDS in a few short years unless effective treatments are rapidly discovered and made accessible to all who need them. By 1991 -- only two years from now -- the U.S. will have, by the most conservative estimates, well over 200,000 persons with full-blown AIDS, most of whom will be totally dependent as a result of being very ill, uninsured, and impoverished.

Not only the medical community, but all of U.S. society will soon experience a catastrophe: a breakdown of our health care delivery system, a significant deterioration in general access to good medical care, an erosion of our civil liberties, grave economic problems, and terrible suffering. Certain hospitals in our large urban centers are already experiencing the first wave of the impending calamity. This breakdown in services will undoubtedly spread across the nation.

The urgent need for expanded research, education, and prevention programs to combat AIDS has been well-documented. In their highly regarded assessments of the epidemic, the former Presidential Commission on the HIV Epidemic and the Institute of Medicine of the National Academy of Sciences have both called for much expanded efforts in federal public health programs to curb the spread of HIV-infection and to care for those already ill. In its approval of the AIDS Amendments of 1988, Congress, has, in fact, recognized the need for an effective federal response to meet urgent research and education needs.

There is no greater threat to the very security of this country than the deadly epidemic disease now spreading uncontrolled; it will become the major killer, nationwide, of its young adults and infants, as it already is in New York.

AmFAR, therefore, supports a $450 million increase in 1990 federal funding to fight such an epidemic.

Controlling HIV-Spread Among Drug Abusers

The HIV epidemic is becoming increasingly related to intravenous drug use, as was recognized by the former Presidential Commission. Therefore, this country desperately needs a system that can deliver treatment-on-demand for addiction. The Alcohol, Drug Abuse, and Mental Health Block Grant program created by the Anti-Drug Abuse Act of 1988 must be enlarged by $150 million to add at least 50,000 addiction-treatment slots. If wisely apportioned to target areas with the highest prevalence of drug use, this will be a sound investment that will pay in reduced drug-related crime, reduced addiction-related HIV-infection and disease, and reduced numbers of men, women and children with AIDS.

Several studies have demonstrated that even among drug users, education and counseling are effective in reducing both needle-sharing and sexual high risk behaviors. Therefore, much expanded risk reduction programs, targeted at substance abusers, must be supported. We recommend that $50 million be provided for this purpose, including $10 million for demonstration projects to identify the most effective programs. Indeed, let us not forget that most drug users are heterosexual and that, while they may acquire HIV-infection through the sharing of contaminated needles, they transmit it sexually to others, usually women and, through them, to their infants. Infected drug users are the major route through which HIV-infection is now silently spreading to the general heterosexual population. Heterosexual drug users, their sexual partners (one third of whom are not drug users) and their children accounted, in 1988, for nearly half of all the new cases of AIDS diagnosed nationwide. This justifies using every effective means to prevent the further spread of HIV-infection among drug users: education, counseling, bleach distribution, and various ways of making sterile needles available to them. No less can be done for the sake of non-drug users.

Testing Programs

Because risk level of exposure varies enormously from person to person, because each individual is the best judge of his or her own level of risk, and because disclosure of infected status and even of previous high risk behavior are stigmatizing, the availability of voluntary, anonymous or confidential testing has been recognized as highly desirable. It is the best means not only to encourage persons who may be at risk to ascertain their infected status, but for them to receive pre- and post-counseling and so become able, depending on the case, either to protect themselves or to avail themselves of medical treatment and, most importantly, to protect others. That this testing system works has been abundantly demonstrated by its effectiveness: in combination with educational and supportive community efforts, it has effectively stemmed the spread of HIV-infection in the gay community.

The changing pattern of the HIV-epidemic, namely its currently wider geographic and demographic spread, requires larger numbers of testing sites to meet expanding needs.

We recommend an additional $50 million above the Administration's request for testing and counselling services in support of both anonymous and confidential testing combined with counselling programs.

Community-based Service Organizations

Community-based organizations have effectively provided crucial educational and care services to people with HIV-disease since the start of the epidemic. They have the advantages of community-location, cultural sensitivity, credibility and dedication to their own people. They must be funded directly. Past Congressional attempts to do so through grants to the states have been largely unsuccessful. Therefore, we request that an additional $45 million be allocated to the Centers for Disease Control to directly support community-based organizations, as well as national organizations with high credibility in the minority and gay communities.

Community-based Treatment Research

Community-based programs for clinical research on AIDS -- unlike research carried out in academic institutions -- have the advantage of providing quality care and of advancing treatment research through the services of community-based physicians. They greatly enlarge the total pool of physicians involved in such research and make promising treatments accessible to large numbers of sick individuals to whom such treatments were previously denied. The National Institute for Allergy and Infectious Diseases should be allocated a minimum of $24 million to stimulate this highly cost-effective, compassionate and effective approach to treatment research.

Home-based Care

Even when it reaches the advanced state of AIDS, HIV-disease is a chronic condition that causes only occasional acute medical crises. Most people with AIDS can live at home most of the time provided regular medical care and supportive assistance is available to them.

Nonetheless, many people with AIDS now languish inappropriately in costly acute-care settings, namely hospitals, only because they cannot be discharged to an out-of-hospital, less costly, home-based care service. Although funding for home-care services was authorized in the AIDS Amendments of 1988, such funding has, unacceptably, not been made available. This situation is absurd, wasteful and cruel. We implore that $100 million be appropriated to the Health Research Services Administration for home-based care.

Behavioral Research

The National Institute of Child Health and Human Development has been developing comprehensive research into the sexual practices of Americans. This research is critical to the design of optimal risk reduction programs so as to decrease unsafe sexual practices; it is also needed to provide the knowledge on which to base the development of models of the future epidemic, and related economic planning. Congress must ensure that $15 million is earmarked to implement this vital study.

Appropriations for Life-Extending Medications

Long-term solutions must be developed to ensure that life-expanding medications are made available to those who cannot afford them. Congress has acted admirably in providing short-term appropriations for the drug AZT. However, as remarked recently by Health and Human Services Secretary Louis W. Sullivan, "a series of 'one-time' appropriations is not the most desirable way to address the issue of support for the purchase of AIDS drugs." More comprehensive solutions are required that avoid the diversion of funds from HIV research, education and prevention programs. Until that time, the Health Resources and Services Administration should be provided $30 million for AIDS-related medications.

Pediatric AIDS Research

Unknown thousands of children have acquired HIV-infection in the womb or at birth. During a recent six-month period, one out of 71 children born in New York City was found to test positive for antibodies to HIV, indicating an alarmingly high infection rate among pregnant women (1/71). About one-half of the children born to HIV-infected mothers are themselves infected. These children show symptoms of AIDS within a few weeks or months of birth, and most die within two years. Few reach school age. The immune system of infants is very different from that of adults, not only in the degree of maturity, but in its response to infectious agents. In addition, children often metabolize drugs and respond to pharmacological agents differently from adults. The effects of HIV on infants and their response to preventative and therapeutic interventions require immediate study.

We recommend that the Pediatric AIDS Research activities at the National Institute for Child Health and Human Development be expanded by $7 million, and that pediatric care demonstration programs be increased by $16 million.

Epidemiology

Finally, AmFAR strongly supports the continuation and expansion of the Centers for Disease Control's epidemiological surveys, as contained in the President's budget.

The health of all Americans should be the highest priority in the budget process; funding for AIDS-related programs should not come from the budgets of other vital health care and medical research programs.

Please, gentlemen of the committee, have the strength and courage to increase HIV-related allocations by $450 million so that the essential research, education, and care priorities just mentioned can be funded. Future generations will remember and judge us, I assure you, for what we did about HIV disease in our time.

Thank you.

Senator HARKIN. Dr. Krim, thank you.

Do we have enough money in research now? Are we saturated?

Dr. KRIM. I can tell you, you know it is difficult to measure, but when my foundation issues a request for proposals, we receive each time 700 letters of interest from scientists requesting funding while they know we can give out 10 to 20 grants.

Senator HARKIN. Are they all legitimate requests?

Dr. KRIM. Yes; they are.

Senator HARKIN. We have $1.6 billion in this program now. We have come up 24 percent just in the last year, just a 1-year increase.

Dr. KRIM. Yes; but the epidemic has doubled. The epidemic increases by 100 percent per year.

Senator HARKIN. I thought the number of new cases, I thought AIDS was now basically isolated to certain groups, drug users——

Dr. KRIM. No; that is exactly what my testimony says not so. Drug users are at high risk of acquiring the infection because they exchange dirty needles, but they are sexual human beings. They have sex, and most of them are heterosexual and they pass the infection on to their spouses or their girlfriends, and they in turn pass it on to their children. Women of the group is where the rate of infection is increasing the fastest at this moment. So it is not contained.

Senator HARKIN. I will have to think more about that. I was under the impression that basically the spread was not growing.

Dr. KRIM. No.

Senator HARKIN. It was more isolated.

Dr. KRIM. No; you see, it may appear so to some people because what we do when we measure the size of the epidemic, we count the number of cases of AIDS, but there is a very long incubation period between infection and AIDS. As I mentioned earlier, we know now that all people infected are going to become sick with AIDS and die unless treated with effective treatment that we still do not have.

There is a very long incubation period between infection and clinical disease, so the cases of AIDS we count today are among people who became infected on average 8 years ago. So it is very misleading to judge the future on the basis of only the cases of AIDS we see today.

Senator HARKIN. Thank you very much, Dr. Krim. I appreciate your being here.

Senator Burdick, I have to leave for about 20 minutes. Could you chair for about 20 minutes?

Senator BURDICK. I will do my best.

Senator HARKIN. Thank you very much.

STATEMENT OF JAMES L. HOLM, CO-CHAIR, BOARD OF DIRECTORS, NATIONAL GAY AND LESBIAN TASK FORCE

Senator BURDICK [presiding]. Next is James Holm.

Mr. HOLM. Good morning.

Senator BURDICK. Good morning.

Mr. HOLM. I am James L. Holm, co-chair of the board of directors of the National Gay and Lesbian Task Force. The task force is the oldest national gay and lesbian advocacy organization in the

United States and serves as chair of the Appropriations Task Force of the NORA coalition—the National Organizations Responding to AIDS. The coalition has prepared and submitted for the record an alternative appropriations proposal for fiscal year 1990. In the brief time I have today, I want to highlight what NGLTF believes are some of its key points.

The NORA recommendation calls for just over $2 billion in AIDS-related spending as part of the Labor, HHS appropriation in 1990. This reflects needs for AIDS activities as determined by the agencies and is in line with continuing recommendations of the Institute of Medicine for $2 billion in spending on research and prevention in 1990.

Nonetheless, even this higher level provides insufficient resources for a number of priority programs authorized by Congress last year in Public Law 100-607. Increased spending is essential to meet the changing patterns of the epidemic as it expands demographically, posing new challenges in prevention and service areas.

In addition, our progress in the research area continues. New avenues are open for exploration while some areas remain unexplored since the beginning of the epidemic.

In proposing this alternative plan for spending, we are all too aware of its deficiencies, particularly the care of those with HIV disease. AIDS threatens to overwhelm the public hospital system in many communities, and our proposal does not begin to provide the level of the system that is needed to care for those with AIDS to ensure that the system will be functioning for poor people who require a range of health needs and care.

In seeking this level of spending, we recognize that other biomedical research care and prevention programs are facing significant reductions in funding in the proposed 1990 budget. We joined in opposing those cuts. We believe the Nation's commitment to public health should not be selected, and the budgetmaking process should not pit diseases against one another.

Our highest priorities for expansion of Federal resources in the fight against AIDS are increased support for care for persons affected by HIV ranging from direct primary care for low income individuals to mental health services for those affected by HIV.

Wider efforts to prevent the spread of HIV infection through community based target efforts continue the need to be expanded.

Progress in treatment research has also increased the demand for testing and early intervention beyond what is anticipated in the President's budget request.

We continue to be concerned about the level of research activity into treatments and a cure for HIV related disease. As the number of potential therapies increases, we must be certain that the NIH has sufficient resources to expand its capacity to test those drugs. We are particularly excited about the potential of NIAD's new community based clinical trial efforts and believe it merits a higher level of funding than anticipated by the President's budget.

PREPARED STATEMENT

This subcommittee has provided invaluable leadership in our Nation's response to the AIDS epidemic. As someone who works with those on the front lines of the AIDS epidemic on a daily basis, we are confident that under your guidance we will again be able to count on this subcommittee to provide the resources needed by the Federal agencies and community organizations involved in treating, preventing, and finding a cure for AIDS.

Thank you.

Senator BURDICK. Thank you very much.

[The statement follows:]

STATEMENT OF JAMES L. HOLM

Mr. Chairman, I am James L. Holm, co-chair of the board of directors of the National Gay and Lesbian Task Force. I also serve as acting executive director of the National AIDS Network, which works with over 600 community-based AIDS organizations around the nation. NGLTF is the oldest national gay and lesbian advocacy organization and serves as chair of the appropriations task force of the coalition National Organizations Responding to AIDS. The NORA coalition has prepared, and submitted for the record, an alternative appropriations proposal for fiscal year 1990. In the brief time I have today, I want to highlight what NGLTF believes are some of its key points.

The NORA recommendation calls for just over $2 billion in AIDS-related spending as part of the Labor-HHS appropriation in fiscal year 1990. This request is approximately $500 million greater than the President's request for 1990 and is nearly $800 million above current spending. This reflects needs for AIDS activities as determined by the agencies and is in line with the continuing recommendations of the Institute of Medicine for $2 billion in spending on research and prevention by 1990. Nonetheless, even this higher level provides insufficient resources for a number of priority programs authorized by Congress last year in P.L. 100-607.

Increased spending is essential to meet the changing patterns of the epidemic as it expands demographically, posing new challenges in the prevention and services areas. In addition, as our progress in the research area continues, new avenues are opened for exploration, while some areas remain unexplored since the beginning of the epidemic.

In proposing this alternative plan for spending, we are all too aware of its deficiencies -- particularly in meeting the care needs of those with HIV disease. AIDS threatens to overwhelm the public hospital system in many communities, and our proposal does not begin to provide the level of assistance that is needed to care for those with AIDS and assure the system will be functioning for poor people who require care for a range of health needs.

In seeking this level of spending, we recognize that other biomedical research, care, and prevention programs are facing significant reductions in funding in the 1990 proposed budget. We join in opposing those cuts. We believe the nation's commitment to public health should not be selective and the budget-making process should not pit diseases against one another. While we believe that all efforts against disease will benefit from the experience and knowledge gained from the battle against AIDS, we also recognize that we could not have made the progress against HIV that we have without the basic research that predated this epidemic. We must find the resources to fund all these needs adequately.

Our highest priorities for expansion of federal efforts in the fight against AIDS in 1990 are increased support for care for persons affected by HIV (ranging from direct primary care for low income individuals to mental health services for those infected with HIV) and wider efforts to prevent the spread of HIV infection through community-based targeted activities (ranging from expanded access to drug abuse treatment to behavior change counseling and education to prevent sexual transmission of HIV). Progress in treatment research has also increased the demand for testing and early intervention beyond what is anticipated in the President's budget request. Our progress in research is meaningless unless we assure access to those treatments for all Americans, not just those wealthy enough to afford them. Our hope for reducing care costs in the long-term are directly related to our continued willingness to invest in prevention programs -- the only vaccine against HIV we will have for some time.

We continue to be concerned about the level of research activity into treatments and a cure for HIV-related disease. As the number of potential therapies increases, we must be certain that the NIH has sufficient resources to expand its capacity to test those drugs. Funds, staffing, and space should no longer be the excuse for delays in getting promising therapies into the clinical trial system. We are particularly excited by the potential of the NIAID's new community-based clinical trial efforts, as authorized in P.L. 100-607, and believe it merits a higher level of funding than anticipated by the President's budget and the NIH request.

Mr. Chairman, this subcommittee has provided invaluable leadership in our nation's response to the AIDS epidemic. As someone who works with those on the front lines of the AIDS battle on a daily basis -- including those fighting in your home state of Iowa -- we are confident that under your guidance, we will again be able to count on this subcommittee to provide the resources needed by our federal agencies and community organizations involved in treating, preventing, and finding a cure for AIDS.

STATEMENT OF DR. NANCY I. GARFIELD, ASSOCIATION FOR COUNSELING AND DEVELOPMENT COALITION FOR AIDS PREVENTION AND EDUCATION

ACCOMPANIED BY BILL BAILEY, AMERICAN PSYCHOLOGICAL ASSOCIATION

Senator **Burdick**. Our next witness is Nancy Garfield, Association for Counseling and Development Coalition for AIDS Prevention and Education.

Welcome to the committee.

Dr. **Garfield**. Good morning.

Senator **Burdick**. You may proceed any way you wish.

Dr. **Garfield**. Good morning, Senator Burdick, and greetings from Kansas. Thank you for the opportunity to testify regarding the——

Senator **Burdick**. Any rain down there?

Dr. **Garfield**. Yes; the day before yesterday. It was wonderful.

Regarding prevention of AIDS. I am Dr. Nancy Garfield, and I am director of the training program for psychology service at the VA Hospital in Topeka. I am also a member of the Government Relations Committee for the American Association for Counseling and Development, and at the VA I work with veterans from Kansas, Missouri, Nebraska, North Dakota, South Dakota, and Iowa providing counseling for HIV testing and AIDS education.

I am here testifying today on behalf of the Coalition for AIDS Prevention and Education—CAPE—a group of over 30 national organizations concerned with AIDS. CAPE represents the prevention task force of the National Organization Responding to AIDS as a mental health liaison group, AIDS subcommittee.

Our funding recommendations are consistent with the NORA appropriations request you heard earlier presented to you this morning. In addressing CAPE's funding priorities, I will focus on the appropriations for Alcohol, Drug Abuse, and Mental Health Administration [ADAMHA], and the Centers for Disease Control [CDC].

The central features of CAPE's prevention proposal are an additional $45 million for preventing AIDS among IV drug abusers over the amount provided in the President's budget. ADAMHA's proposed administrative changes which would compromise the effectiveness of education, outreach, and treatment kinds of programs among IV drug users, and we urge that the committee direct ADAMHA to fully accept its responsibility in AIDS services, particularly in the area of IV drug user prevention outreach and treatment demonstrations.

Community based organizations continue to be the best example of the Nation's response to the AIDS epidemic, and we urge that an additional $45 million be directed to support these activities, focusing especially on the needs of hard-to-reach populations.

We urge the committee to ensure that the CDC allows community-based organizations to remain free to conduct the most effective prevention programs possible.

Counseling persons about the methods to reduce high risk behavior through HIV testing and consulting programs is really critical, and we strongly urge the appropriation of an additional $50 million above the adminstration's request to expand the CDC's existing programs, with a 50/50 split between anonymous and confidential testing.

The mental health consequences associated with HIV testing are grave. We urge that the committee provide $10 million in funding for ADAMHA to support the demonstration program authorized in Public Law 100-607 for the persons experiencing serious mental health complications related to HIV testing.

The recent report of the National Research Council argues that research on effective prevention strategies is one of the most critical AIDS research needs. The kind of behavior research that is done is one of ADAMHA's chief responsibilities, but it has been seriously curtailed since 1980.

Moreover, behavior change research remains only one of the agency's AIDS research interests. We urge that the subcommittee direct ADAMHA to place its highest priority on behavior change research. It is very important. It should be directed to initiate a program of randomized field tests of community based prevention programs consistent with the NRC report.

PREPARED STATEMENT

Finally, in working with the National Institute on Child Health and Human Development to fund the national survey of health and sexual behavior which is critical to the development of accurate estimates of the number of HIV infected people, we urge the committee to direct HHS to expeditiously move forward with the testing of the survey instrument and to support the conduct of the full survey as proposed in the President's fiscal year 1990 budget.

Thank you again for the opportunity to testify.

[The statement follows:]

STATEMENT OF DR. NANCY J. GARFIELD

I would like to take this opportunity to thank the Subcommittee for this opportunity to present testimony regarding prevention and AIDS. I am Nancy J. Garfield, Ph.D., Director of Training, Psychological Services, Colmery-O'Neil Veterans Administration Medical Center, Topeka, Kansas and member of the Government Relations Committee of the American Association for Counseling and Development (AACD). I have a Ph.D. in counseling psychology and am currently involved in a number of AIDS activities such as providing pre- and post-test counseling for substance abusers; writing, speaking and training on AIDS education; and, serving as a Board Member of the of the Topeka AIDS Project.

I am here today testifying on behalf of the Coalition for AIDS Prevention and Education (CAPE), a coalition of over 30 national organizations concerned with AIDS in the context of prevention, behavior change and mental health. We are affiliated with the Mental Health Liaison Group and the National Organizations Responding to AIDS and our recommendations are consistent with theirs. These comments focus on our Coalition's three primary goals: enhanced counseling and testing, expanding social and behavioral science research and increased funding for AIDS prevention programs and their evaluations, particularly through the community-based service organizations.

To meet these goals I will address funding needs for the Alcohol, Drug Abuse and Mental Health Administration (ADAMHA) and the Centers for Disease Control (CDC) - the two arms of the Public Health Service most concerned with behavior change, prevention and the mental health aspects of the AIDS epidemic. Consistent with NORA's funding proposal, we urge your Subcommittee to adopt a $2.15 billion budget for AIDS research, prevention and treatment programs in FY 1990.

As the lead prevention agency within the Public Health Service, CDC is struggling to implement a comprehensive program to prevent the spread of HIV infection, including surveillance, epidemiologic studies and information/education activities. CAPE recommends that CDC be funded at $584 million in order to meet expanding prevention needs outlined recently by the National Research Council of the National Academy of Sciences.

Funding for AIDS programs at ADAMHA at $217 million reflects just 13 percent of the entire AIDS budget in the President's FY 1989 proposal, despite the fact that the agency's mission includes the development of models of prevention; AIDS research in mental health, substance abuse and behavior; and, recommends $289 million for AIDS activities at ADAMHA, an increase of 33 percent over the President's budget. $50 million, of this sum reflects a transfer of funds from CDC to NIDA for IV drug prevention.

Prevention Related Services: Getting the Message Out and Making It Work

Since the beginning of the AIDS epidemic, it has been widely acknowledged that in the absence of a cure or vaccine, prevention offers the only means of limiting the spread of this disease. Prevention efforts range from the conduct of voluntary and preferably anonymous counseling and testing to comprehensive behavior change and education programs. To accomplish the our prevention goals, CDC and ADAMHA must expand and enhance their role in designing models and funding prevention related services.

Given the increasing numbers of infected drug users, the NORA Prevention Task Force recommends spending an additional $45 million on preventing AIDS among IVDUs over and above the amount provided in the President's budget. We are greatly concerned by the proposed administrative changes in ADAMHA operations which would compromise the effectiveness of the education, outreach and treatment efforts among IVDUs. Relationships have been established between the substance abuse treatment community, the state departments of substance abuse and the National Institute on Drug Abuse (NIDA). The President's FY 1990 budget has sent unfortunate signals that the AIDS drug abuse prevention effort may be shifted away from the National Institute on Drug Abuse (NIDA) to other agencies in the PHS that do not have the historic linkages, personnel or financial resources to administer such critical programs.

We encourage the Committee to provide language in its report urging ADAMHA to fully accept its responsibility in AIDS service issues. In addition to prevention outreach, we urge the Committee to direct NIDA to maintain and expand its drug treatment demonstration program. Not only does this effort expand treatment slots for high risk individuals, an issue highlighted by the President's AIDS Commission as one of the most pressing AIDS concerns, but it also improves our knowledge about the efficacy of different treatment approaches.

Community based organizations continue to be cited as best example of this nation's response to the AIDS epidemic and we urge that an additional $45 million be directed to support these activities. Funding should be based on geographic diversity as well as absolute incidence. In funding to CBOs, CDC must take into account the special needs of hard to reach populations such as institutionalized populations, the homeless, and ethnic minority groups that do not recognize AIDS as a problem in their communities. Adolescents at risk for AIDS often require the most creative forms of outreach and interventions. Interventions must have evaluation components and CDC should work with ADAMHA to explore innovative ways of linking the two agencies expertise and funding initiatives of these two agencies as discussed below.

CAPE remains concerned about efforts that limit the effectiveness of these the community based prevention programs. CBOs must be able to use the explicit messages to prevent high risk behaviors. Data accumulated in the development of CDC's FY 1988 education campaign suggests that the American public is prepared for such explicit education messages when appropriately targeted to the intended subgroups. Any attempts to bind the hands of CDC in responding to the prevention needs of the nation run counter to the best advice of the scientific community. In addition, state agencies must be encouraged to use their CDC funds to work with and fund these organizations directly. With regard to funding mechanisms in this area, we urge CDC to maintain its program of cooperative agreements with CBOs and localities in the areas of highest incidence.

One of the most pressing areas for the CAPE groups is in the area of counseling and testing for the AIDS antibody. The public health community has consistently argued that if the HIV antibody test may be an appropriate adjunct to counseling in the effort to promote behavior change away from high risk practices that transmit infection. Testing is not the public health goal; it is behavior change and counseling is the best mechanism for achieving behavior change. Thus we strongly urge appropriating an additional $50 million above the $119 million included in the Administration's request to allow CDC to expand its existing counseling and testing program. Consistent with the language in P.L. 100-607, we urge that these counseling and testing funds be evenly split between anonymous and confidential testing programs. Moreover, we encourage CDC to work with ADAMHA to assess the relative impact of behavior change counseling alone versus counseling with testing.

We are especially concerned about the mental health consequences associated with HIV testing. Increasingly, we have become aware of the long term mental health consequences of HIV disease, including extreme depression, disabling levels of anxiety, suicide and suicide ideation. Special needs of the family and friends of AIDS patients must also be considered. This is not only a mental health emergency of the first magnitude, but it also presents some serious public health issues. Some modicum of support must be provided to ensure that HIV infected persons maintain low risk behaviors in order to sustain the gains already achieved. Therefore, we urge that the Committee provide $10 million in funding for the National Institute of Mental Health (NIMH) to support the demonstration program authorized in P.L. 100-607 for services to persons experiencing serious mental health complications related to HIV testing, their families and others.

Behavior Change Research: Changing Community Norms

Despite the remarkable achievements we have seen in behavior change among some groups at risk for AIDS we do not yet have the foundation of knowledge necessary to wage a real war against this disease. Historically, behavioral research, which is chiefly the responsibility of the Alcohol, Drug Abuse and Mental Health Administration (ADAMHA), has been seriously curtailed since 1980. As AIDS has proven, the reduction in all behavioral research has left the nation poorly equipped to deal with the health crisis of AIDS. This situation has been repeatedly addressed by advisory groups such as the National Academy of Sciences and the President's Commission on the HIV Epidemic. Most recently, the National Research Council issued a report condemning the continued deficits in this area. This landmark study provides a roadmap for expansion of the critical role of the behavioral and social science research agenda and AIDS. CAPE Force commends this report to the Committee as a planning tool for assessing the Administration's proposed FY 1990 research and prevention services budget on AIDS.

Over the past several years, there has been some problem within ADAMHA in focusing the agency's work on its central mission in AIDS: behavior change. Too much attention has been focused on other research areas such as the mechanism of action of the virus in the brain. While these other topical areas will provide important knowledge in the fight against AIDS, they are also the subject of significant research funded by other institutes. The other major areas in which ADAMHA funds research projects (i.e., behavior change, psychological response, coping and stigma), are areas which no other agency is addressing. We urge that the Committee direct ADAMHA to place the highest research priority on behavior change.

Our funding recommendations would permit ADAMHA to initiate a program of randomized field trials of community-based prevention programs. Repeatedly, government watchdogs agencies like GAO and OTA have highlighted the absolute absence of high quality research data about the benefits of prevention efforts. A randomized field trial would provide just the kind of data needed to show which kinds of prevention projects work and which don't. The difference between the behavior of individuals at the epicenter's and those at other sites across the United States reflect the results that can be expected from concerted and systematic community organization and programs focused on knowledge, skill, and shifting community norms. CAPE urges the Committee to direct that ADAMHA inaugurate a new initiative in this area along the lines of the heart disease and smoking cessation community trials undertaken by NIH.

In addition, small scale evaluations should be funded, examining the effectiveness of individual interventions targeted at specific groups such as: black and latino gay and bisexual men, adolescents experimenting with high risk sexual activity, persons using drugs and alcohol during sex, and ethnic minority women. Data originating from these studies would compliment the clinical trial effort and would enhance the overall knowledge base. One mechanism the Committee should consider for this kind of effort would be a joint grant making program between the ADAMHA and CDC. Through such an effort, any community based prevention program seeking funding from CDC would have to be submitted simultaneously with a research application to NIDA or NIMH linking service providers with their local research community.

One final area of concern: the conduct of surveys which will add to our knowledge base about how to address AIDS. CDC is involved in a number of surveys which are reviewed in the National Research Council report. Consistent with the NRC study, the Committee should urge the reformulation of the family of surveys as probability samples. CDC is working with the National Institute on Child Health and Human Development (NICHD) to fund the national survey of health and sexual behavior. This effort is critical to the development of appropriate estimates of the number of persons who are HIV infected in this country. CAPE urges the Committee to direct HHS to expeditiously move forward with the testing of the survey instrument without any further modifications and should support the conduct of the full survey as proposed in the President's FY 1990 budget.

Senator BURDICK. Thank you very much. I just have one question.

I am not an expert like you are, but as I sit here in other committee hearings there are a great many organizations involved in this fight, and that is fine. But how do we avoid the duplication of efforts?

Dr. GARFIELD. I think the organizations are working together as much as possible.

Senator BURDICK. Do you have a clearinghouse? Do you have a central area, or are you going to have labs doing the same thing.

Mr. BAILEY. Senator Burdick, I am Bill Bailey with the American Psychological Association. There is a significant effort both within the Public Health Service and outside of the Public Health Service to try to coordinate the efforts as much as is possible.

At this point in the epidemic we have different populations that need to be addressed in different kinds of ways, so that it is important to try to reach out to them with a variety of different tactics and different strategies, but we are trying to coordinate them through programs, in particular the Centers for Disease Control, in coordinating the various efforts.

Senator BURDICK. That is fine. I do not see why we should plow the field three or four times.

Dr. GARFIELD. We are working very hard to avoid that.

Senator BURDICK. Thank you very much.

STATEMENT OF DR. JAMES S. KAHN, PRESIDENT AND DIRECTOR, MUSEUM OF SCIENCE AND INDUSTRY

Senator BURDICK. Our next witness is Dr. James Kahn, president and director of the Museum of Science and Industry.

I presume you are from Illinois?

Dr. KAHN. Yes; I am, sir. I am from the city of Chicago.

Senator BURDICK. I was ordered by Senator Simon to give you the best welcome possible, so you are getting the best welcome possible.

Dr. **Kahn**. North Dakota, Illinois, who could ask for anything better? Thank you, Senator Burdick, for that very nice greeting. I will submit my written statement for the hearing record upon the conclusion of my remarks.

I am Jack Kahn, president and director of the Museum of Science and Industry in Chicago, America's oldest and largest science museum. We host approximately 5 million visitors each year at the museum.

I am here on behalf of the American Science Museum community to request that you allocate $5 million in fiscal year 1990 for science museums to build AIDS education exhibits. We are requesting that this $5 million be part of the increased funds which you appropriate for the Centers for Disease Control in fiscal year 1990. We ask that the funds be distributed competitively and that private matching funds be required so that scarce Federal dollars are leveraged and stretched.

This request is being made by science museums from California, Boston, Detroit, Cleveland, Baltimore, Philadelphia, Louisville, and other cities across the country. Attached to my written statement are letters of support from these museums, who collectively host tens of millions of visitors each year. Roughly, 5 million of those visitors are estimated to be adolescent youth, the target population for our proposed program.

The bottom line is that an AIDS vaccine will not become available in the foreseeable future. Education and prevention, therefore, must be aggressively pursued. Science museum exhibits are a highly effective medium for behavioral intervention. It is the opinion of many experts that visiting a science museum represents an excellent opportunity to effectively teach people that changes in their lifestyles can lead to improved health.

The science museum community is well positioned to educate youth on the link between IV drug use and AIDS. Many science museums such as ours service large inner city and minority populations, populations through which AIDS is spreading most rapidly. We can access kids before they become addicts. We can access kids before they become sexually active.

The science museum community can also help educate the public about how AIDS is not transmitted. Too many Americans still believe that AIDS can be spread by casual contact.

In addition, science museum exhibits can demonstrate the significant spinoffs from the Federal investment in AIDS research. They can serve to help build a constituency for the necessary Federal support to discover a vaccine.

The AIDS Amendment Act of 1988 provides the CDC with the authority to carry out a museum-based prevention education program. In addition, the recent National Research Council report included the following recommendations. I quote, "Innovative approaches to AIDS prevention programs must be established in a planned manner that reflect well-established principles about the adoption and diffusion of new ideas."

PREPARED STATEMENT

Mr. Chairman, this recommendation outlines a need which science museums can fill. The science museum community is prepared and willing to join the battle to educate the American public in high risk communities to prevent the spread of AIDS. I hope your committee will accept our offer and will allocate the necessary funds to initiate this important national project.

Thank you again for providing me the opportunity to testify before you, sir.

Senator **Burdick**. Thank you very much.

[The statement follows:]

STATEMENT OF DR. JAMES S. KAHN

Mr. Chairman, I appear before your Committee wearing two hats -- one formal, the other informal. My formal hat is that of the President and Director of the Museum of Science and Industry in Chicago, the oldest and largest science museum in America. My informal hat is that of a citizen advocate, an individual interested in ensuring that we utilize all possible means to educate Americans about AIDS.

The Museum of Science and Industry hosts almost five million visitors each year. A very large portion of our visitors are inner city youth. Some come in voluntarily; some are brought in by their schools. Visitors at our Museum are taught basic scientific principles through interacting with exhibits. Our most recent exhibits, for example, deal with our hearts and with Learning Disabilities. In our health education areas, we demonstrate both function and behavior modifications to reduce health risks. Mrs. George Bush, our First Lady, opened our exhibit on Learning Disabilities and was impressed with the illuminating manner by which this subject was presented. She was particularly pleased with the way in which persons could obtain information on learning disabilities if they suspect friends or relatives have a disability. Based on research conducted by a number of objective organizations, science museum exhibits are a highly effective medium for teaching people that lifestyle changes can lead to improved health. (I've attached references to this research to this testimony.)

A group of large and small science museums from across the country, including ours, have indicated an interest in building AIDS education and prevention exhibits. The Museum of Science and Industry has been working with the Centers for Disease Control to determine funding availability. The former director of the CDC, the current Assistant Secretary for Health-designee, expressed an interest in funding AIDS education exhibits, and regretted that Congress has not appropriated the necessary funds. I am here to ask you for the necessary appropriation.

The purpose of building AIDS exhibits at science museums is two-fold. The primary purpose is to target high-risk adolescents to effectively teach them that IV drug use, (contaminated hypodermic needles), causes AIDS transmission. AIDS is spreading rapidly among IV drug users. We will work to demonstrate for youth the link between IV drug use and AIDS: our goal is to implement a prevention education program aimed at America's youth before they become addicts.

Within the communication constraints imposed by Congress and the Centers for Disease Control, we will also target adolescents to effectively teach them that certain sexual behavior causes AIDS transmission.

In addition to targeting America's youth, science museums can establish broad-based AIDS health education and communications programs for adults of all ages. We must teach citizens that AIDS transmission cannot be spread by casual contact. We must reduce public fear of AIDS and counter public discrimination of people with AIDS.

A broad-based communications strategy must also educate the American public about the importance and value of our massive federal investment in AIDS research. The American public has not been effectively told that federal AIDS research dollars have vastly improved our knowledge and understanding about the biology of the AIDS virus and how it fatally perturbs the human immune and nervous systems. Americans need to be proud of this program and reassured that some of the world's best scientists are working on this problem. Eventually they will discover and develop new therapies that effectively combat this terrible disease. We would like to help you build a constituency for this on-going federal research project.

With a modest level of funding through the Centers for Disease Control, the science museum community can become an active and highly effective participant in the national AIDS education and prevention program. Attached to my written testimony you will find letters from science museums across the United States -- Boston, Detroit, Louisville, Baltimore, Cleveland, Los Angeles. These letters demonstrate a willingness to participate. The science museums listed collectively host millions of visitors annually. About 3.4 million of those visitors are adolescent youth, the primary target of our proposed program. The Museum of Science and Industry alone here in Chicago, with approximately five million annual visitors, will be visited by 2.2 million school-age children.

I appear before your Committee today, Mr. Chairman, to request that you provide the necessary funding for CDC to help support AIDS exhibits in science museums. I recognize that such a program should not rely solely on federal funds, so I recommend that you or CDC require participating science museums to secure matching private funds or in-kind contributions. This way, your Committee ensures joint ownership of this effort by community, corporate and local involvement in each project.

I request that you appropriate $5 million for museum projects in Fiscal Year 1990. This amount should be distributed through competitive grants, and should be used for a series of both permanent and traveling exhibits. Because AIDS research findings are changing so rapidly, a small amount of funds must be made available in subsequent years to keep the exhibits up to date.

With a $5 million federal appropriation and a matching funds requirement, the science museum community can build four or five permanent exhibits at the largest institutions and two or three traveling exhibits for smaller museums. Tens of millions of Americans will experience these exhibits, each of which has a five-year lifetime. Through these exhibits, the public will learn concepts as well as facts about AIDS. The exhibits will complement and supplement other CDC education and communication programs.

The AIDS Amendments Act of 1988 provides CDC the authority to carry out a museum-based prevention program. For Fiscal Year 1990, the Administration requested an 8.5% increase in the "AIDS Research and Education" account. Your Committee has historically committed more resources to AIDS education than the previous Administration, and I ask that you consider funding a national museum-based AIDS education program out of the increased funds which you appropriate for AIDS education in FY '90.

Mr. Chairman, despite current education and prevention programs, the AIDS epidemic continues to spread at alarming rates, especially within minority populations and among IV drug users. The science museum community commands and maintains the attention of all of our nation's youth, regardless of race, as well as America's adult population. Millions of children come in voluntarily; most of the rest are brought in by their schools. As a representative of that community, I urge you to appropriate funds to enable us to help you fight the AIDS battle. As a citizen advocate, I urge you to do everything within your means to help educate the public on this problem, including utilizing the science museum community, a powerful element of our education system.

We've been told that there is no AIDS cure or vaccine in sight. The only real hope for controlling AIDS now, therefore, is education that changes people's behavior. The science museum community can help provide that education with well-focused exhibits aimed at preventing AIDS!

The National Research Council, which includes the National Academy of Sciences, the National Academy of Engineering and the Institute of Medicine, published their findings last month in a book titled AIDS: Sexual Behavior and Intravenous Drug Use. In conclusion, I would like to read for you two of the Committee's recommendations on AIDS education:

> "The Committee recommends that innovative approaches to AIDS prevention programs be introduced in a planned manner that reflect well-established principles about the adoption and diffusion of new ideas."

> "The Committee recommends that programs to facilitate behavioral change be approached as long-term efforts, with multiple and repeated strategies to initiate and sustain behavior change over time."

Mr. Chairman, I am a scientist. Most of my life prior to joining the Museum of Science and Industry was spent at the Lawrence Livermore National Laboratory. I assure you that the science museum community is committed to implementing these important recommendations, and can contribute to facilitating change in health behaviors in the United States.

A number of documents to support this testimony are included in my written statement: I ask that they be inserted in the hearing record.

Thank you for providing me the opportunity to testify before this Committee.

LETTER FROM DR. WILLIAM M. SUDDUTH, PRESIDENT, MUSEUM OF HISTORY AND SCIENCE

April 20, 1989

Mr. Gene S. Brandt
Vice President for External Affairs
& Director of Development
Museum of Science and Industry
57th Street and Lake Shore Drive
Chicago, Illinois 60637-2093

Dear Gene:

Your efforts to seek funding fro exhibits on AIDS Prevention and control are very timely. We have been asked by several local groups to develop an exhibit on AIDS and smaller modules that can be circulated to schools, libraries and shopping malls. As you know, museums have a tremendous impact on public education reaching families, schools and the out of school population. Unfortunately, we can not fulfill the need for an AIDS exhibit without sources of funding. Grants from the Center for Disease Control would result in seed money that could be matched by local and regional private, sector donations. Please let me know if I need to write Senators For or McConnell or Congressmen Natcher, Mazzoli and Hamilton to support your efforts.

Sincerely,

Dr. William M. Sudduth
President

LETTER FROM BRADFORD I. TOWLE, INTERIM DIRECTOR, MUSEUM OF SCIENCE

April 12, 1989

Mr. Gene S. Brandt
Vice President for External Affairs
and Director of Development
Museum of Science and Industry
57th Street and Lake Shore Drive
Chicago, IL 60637

Dear Mr. Brandt,

The Museum of Science in Boston, as evidence of its current public demonstration on "Viral Invaders-From Colds to AIDS", believes it is important to provide the public with information and education on AIDS and its prevention.

We support your effort to obtain funds which all museums interested in developing exhibits and programs in this area can solicit. We would probably apply for such support if the opportunity were available.

Thank you for your effort in this direction to date.

Sincerely,

Bradford I. Towle
Interim Director

LETTER FROM ROBERT S. SCHUG, DIRECTOR OF DEVELOPMENT, CLEVELAND HEALTH EDUCATION MUSEUM

April 11, 1989

Mr. Gene S. Brandt
Vice President for External Affairs
and Director of Development
Museum of Science and Industry
57th Street and Lake Shore Drive
Chicago, Illinois 60637-2093

Dear Mr. Brandt:

I am responding to your letter of April 4th for our President, John W. Fenker, who is currently on medical leave.

The Cleveland Health Education Museum currently has an exhibit on AIDS in place. It is constructed so that we may update it easily as it becomes necessary to do so.

We certainly do support all efforts made to educate the public on this dreaded disease.

Sincerely,

Robert S. Schug
Director of Development

LETTER FROM COREY M. VAN FLEET, PRESIDENT AND EXECUTIVE DIRECTOR, DETROIT SCIENCE CENTER

April 19, 1989

Gene S. Brandt
Vice President - External Affairs
Director of Development
Museum of Science and Industry
57th Street and Lakeshore Drive
Chicago, Illinois 60637-2093

Dear Gene:

Thanks for your letter of April 4, advising me of your intent to find funding for the development of permanent and traveling exhibits on the subject of AIDS education and prevention. I support your efforts and will assist you at every turn.

The issue of AIDS in the urban setting is now, and will become more, crucial as we deal with its roots in science as well as sociology. Education and behavior modification are as important as enforcement in dealing with this scourge. In Detroit AIDS is needle-driven and thus education and information dissemination needs to be available in a multitude of venues including permanent exhibits at the Science Center. Traveling exhibits and programs which may be taken into shopping centers, food and party stores and the basements of our urban churches, shelters and soup kitchens are also valuable. Science museums are the perfect agency for carrying out this message since we have relatively few constraints to reach any targeted public.

Here at the Detroit Science Center we have featured AIDS programming involving the disease itself, its affects on unborn children, the issue of care, and death and dying. I personally am very active on the American Red Cross AIDS_ Education Committee which is a collaborative of many agencies in Michigan trying to focus singularly on this ghastly problem. I applaud your intention to produce a substantial education and prevention program and pledge the support of the Detroit Science Center in any way possible as you create these much needed materials. We will continue to move forward here at the Detroit Science Center, and I would be most pleased to collaborate as possible in helping to identify funding enabling each of us to be successful.

I will talk to you about this issue in the near future, but in the meantime, thank you so much for advising me of your bold step forward in establishing education

programs dealing with the subject of AIDS and its consequences in an urban setting.

Sincerely,

Corey Van Fleet

Corey Van Fleet
President and
Executive Director

LETTER FROM DAVID A. UCKO, DEPUTY DIRECTOR, CALIFORNIA MUSEUM OF SCIENCE AND INDUSTRY

April 19, 1989

Mr. Gene S. Brandt
Vice President for External Affairs
and Director of Development
Museum of Science and Industry
57th Street and Lake Shore Drive
Chicago, IL 60637

Dear Gene:

The California Museum of Science and Industry is extremely interested in the development of educational exhibits on AIDS. Our Museum received $30,000 in planning funds last year from the California Department of Health Services, and we have completed the conceptual design for both a permanent exhibit in our Hall of Health and a national traveling exhibition.

We have shared the results of our planning with Peter Anderson, your Vice President for Programs, who has indicated a willingness to collaborate with us on the implementation of exhibits at both of our institutions, and perhaps other museums as well. Needless to say, we are most supportive of your efforts to secure federal funds for these purposes.

Please let us know how we can be of further assistance.

Sincerely,

Dave

David A. Ucko
Deputy Director

STATEMENT OF ROLAND GARDNER, EXECUTIVE DIRECTOR, BEAUFORT-JASPER COMPREHENSIVE HEALTH SERVICES, RIDGELAND, SC, ON BEHALF OF NATIONAL ASSOCIATION OF COMMUNITY HEALTH CENTERS, INC.

Senator BURDICK. The next witness will be Roland Gardner, executive director, Beaufort-Jasper Comprehensive Health Services, Ridgeland, SC, National Association of Community Health Centers, Inc.

Welcome to the committee.

Mr. GARDNER. Thank you. Good morning, Senator Burdick. I am Roland Gardner representing the Beaufort-Jasper Comprehensive Health Services and the National Association of Community Health Centers. I am speaking on behalf of a national association which represents over 600 community health centers throughout the Nation.

As you know, these centers provide basic comprehensive preventive services to nearly 6 million vulnerable people. I deeply appreciate this opportunity to——

Senator BURDICK. Is this the Migrant Council?

Mr. GARDNER. The Migrant Health Center Service is also in this organization.

Community migrant health centers and related programs are primary care facilities which provide outpatient medical and health service to nearly 6 million low income disadvantaged patients each year, most of whom have no other available source of health care. This includes medically indigent persons who lack public and private coverage, including a significant number of high risk pregnant women.

There are nearly 20 million other Americans in need of basic health care who are not currently served by the programs that are currently funded under community migrant health centers. Community health centers, as I stated, serve mostly disadvantaged people. In 1987, there were 532 community health centers serving 5.2 million persons. In migrant health care, we served approximately 500,000 migrant or seasonal farm workers.

Also, I am speaking on behalf of and in support of the National Service Corps, which provides physicians, professionals to shortage areas and also address the special population served by these groups, which include perinatal, the homeless, substance abusers, and HIV infected persons.

Taken together, these programs form the core of Federal support to make basic health care available to medically underserved communities.

Even though we are meeting the needs, there are a number of areas we still need to address. Community health centers have been shown to be very, very supportive of their communities. We promote the use of preventive health services. We help to improve the health of the communities in which we serve, and there has been a surge in demand for our care.

In Beaufort and Jasper Counties alone during the past year, we have seen a major increase in our users. We are spread across 1,500 square miles. Beaufort County is composed of 99 islands. Some 66 of them are inhabited. We serve 33 of the 99. On an average we provide transportation to 1,000 patients a month to the health centers, and sometimes this amounts to about 25,000 miles of travel cost.

We ask for the recommended support of $65 million for community health centers, $52 million for migrant health programs, and also an additional $32 million for infant mortality reduction.

Without the National Service Corps, Beaufort-Jasper would have been in dire need, in that 5 of the 10 physicians that are currently practicing at this health center either have corps obligations or are on the loan repayment program.

PREPARED STATEMENT

The problems that we continue to have in rural communities deal with malpractice issues. In the past year, we had an average of 25 patients a month who are coming in for medical services. That amount alone, we have to increase that because the number of physicians are currently not seeing clients.

Again, I have included all this in my testimony. I think we have submitted a copy of this to the committee, and we do ask for consideration in support of these programs.

[The statement follows:]

STATEMENT OF ROLAND GARDNER

My name is Roland Gardner, Executive Director of Beaufort-Jasper Comprehensive Health Services, Inc. in Ridgeland, South Carolina and President of The National Association of Community Health Centers, Inc. I am speaking on behalf of The National Association of Community Health Centers which represents over 600 Community and Migrant Health Centers throughout the nation. As you know, these centers provide basic comprehensive and preventive health care to nearly 6 million of America's most vulnerable people, two-thirds of whom are children and women of child-bearing age. Our patients range from economically disadvantaged residents of inner-city ghettos to rural migrant farmworker labor camps and isolated, resource-poor communities, including the homeless and substance abusers. I also intend to speak to you on the newly created homeless health care services.

I deeply appreciate the opportunity to discuss with you today the problems which these health centers face in the current economic climate, and the issue of FY 1990 funding for these federal programs.

I. Community and Migrant Health Centers and Related Programs

Overview

Health centers are primary care facilities which provide out-patient medical and health services to nearly 6 million low-income and disadvantaged patients each year, most of whom have no other available source of health care. These include medically (and, often, economically) indigent persons who lack public or private coverage -- including significant numbers of high-risk pregnant women and children and homeless persons -- as well as Medicare and Medicaid recipients refused care by other private providers (often because of low payment rates or discriminatory practices). In many rural communities, these centers are the only available health care providers for miles.

Nearly 20 million other Americans in need of basic health care are not currently served by these programs due to funding constraints.

Community health programs such as Community Health Centers (CHCs), Migrant Health Centers (MHCs), Health Care for the Homeless (HCH) programs, and the National Health Services Corps (NHSC) are vital components of the provider system needed to pick up the slack and deliver care to the medically underserved.

o Community Health Centers (CHCs) provide prevention-oriented, comprehensive case-managed primary health care services to medically disadvantaged populations in their communities. In 1987, there were 532 CHC grantees serving 5.2 million persons.

- Migrant Health Centers (MHCs) deliver case-coordinated primary health services to an estimated 500,000 migrant and seasonal farmworkers and their families annually.
- National Health Service Corps (NHSC) provides physicians and other health professionals to areas with shortages of these providers. Nearly one-half of all CHC and MHC physicians are assigned by NHSC.
- Services for Special Populations are targeted at particularly high-risk groups within the overall medically underserved population. These include: perinatal services, the homeless, substance abusers, HIV-infected persons, and the elderly.

Taken together, these programs form the core of the federally supported effort to make basic health care available to medically underserved communities. In recent years an increasing proportion of the health centers' patients has come from the most vulnerable population groups. The health centers have actively responded by refocusing their services to meet these special needs.

Even as they are meeting these special needs, health centers have shown themselves to be effective and efficient providers of care:

- They are responsive to their communities. Centers receive a high degree of acceptance and utilization in communities they serve, and have helped to close the health care "gap" that historically separated poor and non-poor Americans.
- They promote the use of preventive health services and reduce reliance on hospital emergency rooms.
- They have significantly improved the health of the communities they serve: Major reductions in infant mortality - as much as 40 percent - have been achieved in areas served by Health Centers, due to the access they provide to high quality maternity and infant care services.
- They provide high quality care, including clinical management of patients, completeness of care, and follow-up.
- They dramatically reduce hospital use and costs for patients. Health Centers' impact on hospitalization costs means that they have more than paid for themselves.

At the same time, however, various problems are increasingly hindering Health Centers from fulfilling their mission to provide care to underserved and vulnerable populations.

- Surge in demand for care - One challenge facing Health Centers is the ever-increasing number of people seeking services. New waiting lists are averaging between 15 and 28 percent of the current patient enrollments. [Health Centers have reported up to a 300 percent increase in the number of pregnant women seeking care, thus placing significant pressure on their limited obstetric services.] In rural areas, closures of hospitals and physicians' offices have left entire communities in great demand of health care services. Between 1986 and 1987, rural centers had a 7.8 percent increase in the number of patients; of these, 83 percent were uninsured. [Furthermore, increasing numbers of homeless persons and those with AIDS are using Health Centers.]

- Populations with special needs - Health Centers and the new Health Care for the Homeless (HCH) program are serving an increasing number of such persons, including:
  - 175,000 pregnant women, or 10% of all low-income pregnant women who delivered in 1988.
  - Approximately 230,000 homeless persons, or about 10% of the estimated homeless population in the United States was served. Nearly half of these were either homeless children or members of homeless families.
  - An estimated 66,000 persons who are infected with the HIV virus.

  Because of their unique needs and conditions, these individuals often require more intensive and more costly care. Their numbers are not expected to diminish in the near future.
- Stagnant or declining resources - While demand for services has increased significantly, funding for Centers has decreased over time. Even with a $20 million increase in this year's appropriation, centers are operating at the same level of funding in 1989 as they were in 1987. In fact, 1989 funding is 25 percent lower than 1981 levels after adjustment for inflation.

  The following areas are currently insufficiently funded: 1) The homeless health care program is currently operating at a $46 million level, while the federal appropriation for FY 1989 is only $15 million; a $31 million cut. 2) Funding for the NHSC has declined precipitously during the 1980s, down from $150 million in 1982 to $45 million in 1989.
- Shortage of available manpower - In addition to funding constraints, shortages in manpower further hinder the ability of Centers to fulfill their mission. Of the 2,500 current physicians in Centers, 1,200 are members of the NHSC. Over the next two years, 900 NHSC physicians will finish their obligation; more than half of them will leave the Health Center system for reasons that the centers and their communities are powerless to change (such as rural isolation, climate, lack of physician colleagues nearby, and the like). Without further assistance, a significant number of Health Centers, especially those in isolated rural areas, could be forced to close.
- The malpractice crisis - The cost of malpractice insurance has exploded over the past three years and now consumes more than 10 percent of the Centers' federal grant support. At the same time, some insurers have refused to cover physicians and nurse midwives for obstetrical services at health centers, not due to any claims history but rather because of the "high-risk" nature of so many health center patients.

Meeting these challenges is critical to the survival of Health Centers, who are a key part of our nation's basic health care system. They are the only federally-supported system that makes entry-level care available to the most vulnerable populations. These high-risk patients are those likely to be left unserved by traditional providers even if they were to be covered by expanded insurance programs. Failure to serve them will cause serious problems for the entire system in terms of health outcomes, costs, and public health.

Few programs have made as significant a contribution to low-income families as cost effectively, or in as high quality a manner, as have Community Health Centers. Preservation of this valued resource requires action to assist Health Centers in addressing the challenges they face and in enhancing their capacity to serve remaining unmet needs.

RECOMMENDATIONS:

Our recommendations, while calling for an increase in funding for these programs, are, we believe, reasonable in light of the huge unmet need, and in recognition of the need to restrain the growth in federal spending.

We firmly believe that providing the recommended funds will produce a tremendous savings to the federal government, both in lives and in dollars.

1) Community Health Centers - $465 million

An increase of $50.2 million over the $414.8 million requested by the Administration would allow:

- continuation of current services in 536 Community Health Centers, 329 of them in rural areas, serving as the provider of last resort to over 5 million underserved persons
- an increase of approximately 3.5% over FY 1989 funding for existing health centers to cover the increased cost of personnel, supplies, and the like
- expansion of services to 200,000 new users, more than half of them in rural areas
- continuation of $19.5 million in special perinatal care grants to 207 Community Health Centers, which have substantially improved care to more than 150,00 low-income pregnant women
- improvements in the scope of services at existing sites, strongly emphasizing the addition of case management services - including outreach, referral and followup care - as well as lab, x-ray, pharmacy, and preventive dental services to centers in rural areas currently providing primarily physician care
- $8 million for high priority capital needs which will benefit rural centers in temporary or non-code compliant facilities and allow needed facility expansion

2) Migrant Health Programs - $52 million

An increase of $4.4 million over the $45.6 million requested by the Administration would allow:

- continuation of current services in 122 migrant programs, nearly all of them in rural areas, caring for 500,000 migrant and seasonal farmworkers who lack public or private insurance and are among the Nation's poorest citizens
- an increase of approximately 3.5% over FY 1989 funding for existing migrant programs

- continuation of $1.1 million in special perinatal care grants to 21 Migrant Health Centers, thus enhancing services to 25,000 pregnant women
- expansion of services to 40,000 new users in rural areas with high impact from migrant and seasonal farmworker populations
- improvements in the scope of services at existing migrant sites, including, where needed, the addition of environmental pesticide screening and community outreach services, as well as lab, x-ray, pharmacy, and preventive dental services.
- $2 million for high priority capital needs to benefit migrant programs in temporary or non-code compliant facilities and allow needed facility expansion

3) Community and Migrant Health Centers

Special Infant Mortality Reduction Funding - $32 million

This amount, which is the same as the Administration request would allow:

- Development of enhancement of perinatal care services, at 250 additional Community and Migrant Health Centers
- Extension of maternity, delivery, and post-partum services to at least 75,000 additional low-income, high-risk pregnant women
- Combined with the $20.6 million in continuing special perinatal care funding (included in the CHC and MHC base funding), permit health centers to serve more than 250,000 high-risk pregnant women in FY 1990.

4) National Health Service Corps

a) Field Placement - $50 million

The recommended level, which is $11 million above the FY 1989 level and $30 million over the Administration's request would:

- Preserve the federally-salaried NHSC field strength of nearly 300 physicians, avoiding the need to eliminate almost 150 such assignees, most of whom are obstetrical providers at rural CHCs and MHCs.
- Support of total field strength of 1,700 NHSC assignees, the same number as in FY 1989, thus avoiding the loss of 450 physicians from rural sites, which would occur at the Administration request level

b) Loan Repayment - $25 million

This increase of $17.1 million over the Administration's request would support:

- 300 health professionals for immediate placement in health centers and other severe shortage areas, compared with only 140 at the Administration's request level
- 400 prospective Loan Repayment agreements with current medical students, thus assuring a small but stable future supply

of health professionals for the neediest health manpower shortage areas.

5) Homeless Health Care - $63.6 million

The amount requested by the Administration would:

- o Stabilize the 109 currently-funded projects at their $46 million current operating level allowing services to nearly 400,000 homeless persons
- o Allow development of 30-40 new HCH projects in high-need communities not currently funded (including rural areas) with growing homeless populations, permitting extension of services to 100,000 more homeless persons
- o permit all HCH projects to improve and enhance services, especially mental health, substance abuse and case management services designed to the patients' core health and social problems

6) AIDS - $50.3 million

This amount would enable health centers to provide services to approximately 13,000 AIDS patients, as well as 42,000 HIV infected persons.

7) Black Lung Clinic - $5 million

This amount would allow Black Lung Clinics to serve approximately 70,000 individuals who have respiratory and pulmonary conditions due to working in coal mines.

Mr. Chairman and members of the Subcommittee, I deeply appreciate the opportunity to present this information to you today. I will be happy to answer any questions.

Senator BURDICK. One question. I have lots of others I would like to ask you, but we are time limited.

Are the migrants getting adequate health care

Mr. GARDNER. I do not think they are getting adequate health care. They could receive a lot more. We provide the services in Beaufort County by having night clinics during the migrant season. They are usually in there from the first of April through the end of July. We provide service from 6 in the evening until the last patient is seen, mostly 1 or 2 in the morning.

We have now expanded the program in that we have a mobile unit that goes out to the migrant camps because of the difficulty getting them in to the service, but there could be a lot more services offered to them. I think it is inadequate, and there has to be some major improvements for health care for migrants.

Senator BURDICK. What is the incidents of AIDS among the migrants?

Mr. GARDNER. We have only had one case in Beaufort in the past 3 years; but again, they come in, they rotate for a period of time, and they are in and out of the county after 3 or 4 months. I do not know the national statistics on that, but we have had only one case in 3 years.

Senator **Burdick**. Thank you very much.

Mr. **Gardner**. Thank you.

STATEMENT OF KAY CLAWSON, M.D., ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Senator **Burdick**. Kay Clawson, M.D., Association of American Medical Colleges.

Dr. **Clawson**. Thank you, Senator.

Senator **Burdick**. Welcome to the committee.

Dr. **Clawson**. I am Dr. Kay Clawson, currently the executive vice chancellor at the University of Kansas Medical Center and also the chairman of the Association of American Medical Colleges.

Senator, before I say anything more I really want to once again express our thanks to this committee for its continued and long-standing support of medical research and medical research training and the institutions we represent. We commend the committee for all the help and hope you can continue that.

We do recognize the severity of the budget problems but believe sincerely that the investment in research and research training is the best investment we can make for the country at this particular time and, therefore, are in strong support of the ad hoc group on medical research's recommendations for funding and hope that you will look at that and increase the budget request so that it is fully funded at the $8.4 billion for NIH and the $933 million for research and research training in alcohol, drug abuse, and the mental health administration.

Now, if that were to happen, we can reverse this trend that the NIH has had of downward negotiating on grants which is very devastating to research. After a scientific peer review sets a figure that it takes to do a research project, then to have it downward negotiated by as much as 10 percent can be devastating and slow the whole research enterprise, and so we hope sincerely that by this funding we can stop that and we can also then fully fund one-third of the approved applications, which is really not heavy funding if you look at it that way. I think it is only about 6,400 of the competing research grants.

We also are concerned about the message that is being sent from the White House and from Congress in terms of our young potential scientists if research funding is not continued and expanded and research education opportunities advanced. For that reason, we support the National Research Service Award Program. This is the program that provides the major training for support of individuals at varying stages of their research careers, and we are requesting $370 million to support approximately 14,200 trainees.

In addition, I would like to mention the biomedical research support grant and the clinical research centers program at NIH. These have come under scrutiny. I do not have the research grant center but I do have the other program, the SRG, and it is absolutely essential in beginning funding for young scientists, and we want to support that.

Also, I would request strongly that you support the health professions education authorization under title 7. This is critical. You can say all you want to about a surplus of physicians in that, but I think we both know that in at least rural America and the inner cities, the primary care residencies, family practice, preventive medicine, geriatric training is absolutely critical as we see it, and then the minority health training program grants, I think, we have to expand. We are losing a major national resource in not getting minorities into the mainstream of research and medicine, and we urge support of those. That means full funding for the exceptional financial need scholarship program, the health career and opportunities program, and the newly authorized grant program for schools demonstrating success in minority retention.

PREPARED STATEMENT

Finally, as I close, one other item that may slip by. We are hoping that you can appropriate the $1 million for the Council on Graduate Medical Education, or COGME as it is called. This is the council that has just really gotten going. It needs at least 2 more years of funding as it looks at information gathering and it meets an advisory mandate for continuing studies on the numbers and types of health professionals. We strongly urge that that not get lost in all this big budget process.

We have submitted our complete budget, and we do appreciate the opportunity to testify.

[The statement follows:]

STATEMENT OF KAY CLAWSON

The Association of American Medical Colleges (AAMC) appreciates this opportunity to comment on the FY 1990 appropriations for the Department of Health and Human Services. The AAMC represents all 127 U.S. accredited medical schools and their students, 440 major teaching hospitals and 88 professional and scientific societies, whose members are engaged in medical education, research and patient care. The AAMC would like to commend this Subcommittee for the continued support of the research and education programs under its purview. Our message is simple: continued federal support for medical research and education is a wise investment in this country's future.

Medical Research: We appreciate the difficult choices that the Congress must make as it attempts to resolve the serious fiscal crisis that confronts this nation. However, the costs of human disease and disability, in suffering, in loss of human potential and in the negative impact on the nation's economy, are not lessened by the magnitude of the budget deficit. The AAMC firmly believes that the principal hope for ameliorating these conditions is a sustained federal investment in biomedical and behavioral research. The research conducted and supported by NIH and ADAMHA provides the foundation of knowledge upon which future preventive, diagnostic and therapeutic advances are built, and benefits many sectors of the economy, such as the expanding biotechnology industry, and enhances our international competitiveness.

The AAMC fully supports the FY 1990 recommendations of the Ad Hoc Group for Medical Research Funding of $8.416 billion for the NIH and $933 million for the research and research training programs at ADAMHA. Part of this request is related to the rising cost of research because of the demand for increasingly sophisticated scientific methods and equipment and for more highly trained scientific personnel. A significant component of this request, however, stems from the NIH practice of "downward negotiations" of the cost of research project grants. These administrative reductions in grants from advisory committee recommended levels -- averaging 10 percent over the last two fiscal years -- reflect a NIH policy objective to maintain stability in the number of competing research project grants. However, cuts of this magnitude are a false economy; they result in less research. The Ad Hoc Group request would restore funding of research project grants to the recommended level and maintain some measure of growth in the system to provide support for new people and new ideas. The Ad Hoc Group proposal would allow the NIH and ADAMHA to fund fully one-third of their approved competing research project grant applications.

Research Training: This nation's medical research enterprise depends upon a steady supply of talented scientists. The National Research Service Award (NRSA) program represents a major source of training support for individuals at varying stages of their research careers. The Ad Hoc Group requests $370 million to support approximately 14,200 NRSA trainees at NIH and ADAMHA. This includes sufficient funds for increased stipends and for full tuition.

BRSG and GCRC: The Biomedical Research Support Grant (BRSG) program provides funds that may be used at the discretion of grantee institutions to support pilot research projects, recruit new scientific talent and develop and maintain shared resources. These grants also allow institutions to cope with interruptions in funding by providing emergency interim project support; critical research projects need not be halted or discontinued, thereby ensuring the continuity of productive research. The Ad Hoc Group recommends $58.5 million for the BRSG program in FY 1990.

The General Clinical Research Centers (GCRC) program provides essential resources to support the clinical research environment at 78 research centers located in academic medical centers across the country. The Ad Hoc Group advocates an 8 percent increase in funding for these centers.

Research Salaries: The AAMC is concerned over the continued loss of highly trained research personnel from the NIH and ADAMHA, and urges Congress to create a Senior Biomedical Research Service within the Public Health Service (PHS) to attract and retain the high-quality scientists needed to maintain this nation's medical research capability. The AAMC also believes that the administration's proposal to cap the salaries for extramural scientists from

NIH grants is a short-sighted attempt that does not adequately address the real issue of the salary scale for PHS scientists.

Health Professions Education: The AAMC believes the Committee should restore adequate funding for the health professions education programs authorized in Title VII of the Public Health Service Act. Lamentably, the Administration's FY 1990 budget once again recommends the elimination of funding for Title VII programs and the authorization of a woefully inadequate loan ceiling of $100 million for the Health Education Assistant Loan (HEAL) Program. In citing aggregate physician manpower figures, the Administration's budget justification sidesteps the true purpose of Title VII and irresponsibly ignores the serious national health manpower problems it is meant to address: the undersupply of primary care physicians; the geographic maldistribution of physicians; the persistent underrepresentation of minorities in medicine; and the shortage of qualified faculty and trained personnel to meet current and future health needs of the elderly and the HIV-positive. The Administration's budget also neglects the federal government's longstanding commitment to equal educational opportunity carried out through Title VII's scholarship assistance for needy and disadvantaged students.

Even though Congressional support of health professions education has been strong and consistent, the deficit crisis has taken an especially large toll on Title VII programs. Since FY 1987, health manpower programs have been reduced by a total of 5.5 percent. When the rate of inflation is taken into account, these losses are further magnified. For FY 1990, we urge the Committee to begin to replenish Title VII appropriations by providing funding marks as close to their program authorization levels as possible.

The Exceptional Financial Need scholarship program has been revised to make exceptionally needy students in all four years of health professions school eligible for a variable amount of scholarship support. Even a $30 million appropriation will only scratch the surface of need among low-income medical students. AAMC urges the Committee to provide full funding for this essential scholarship program. Full funding is also needed for the Health

Careers and Opportunities Program (HCOP) and the newly-authorized grant program for schools demonstrating success in minority retention. Full funding of HCOP will also maximize the scholarship assistance provided through the 20 percent setaside of the HCOP appropriation.

Restoration of adequate funding levels is also critical in several other Title VII programs, including the primary care and preventive medicine residency training authorities, the Family Medicine Departments program, the geriatric training and faculty development programs, the minority health education grants program, the Area Health Education Centers program, and the newly-authorized border health education centers initiative. Other new authorities need sufficient funding as well. Among these are: the AIDS training authority that provides support for faculty and curriculum development and clinical skills enhancement of physicians and dentists; and, a $2.3 million program in the special projects section that supports innovation in faculty and curriculum development and clinical training sites.

The 1988 reauthorization of Title VII also provided a much-needed authorization of appropriations for the Council on Graduate Medical Education (CoGME). Having completed a commendable first report on physician supply and medical education financing, CoGME is moving to achieve its ongoing information-gathering and advisory mandate by conducting studies in a number of important areas. An appropriation of $1 million in each of the next two years is essential to the Council's work and the completion of these studies.

Another HRSA program of interest to the AAMC is the National Health Service Corps. Vast reaches of urban and rural America are still classified as health manpower shortage areas (HMSA's) and 13.4 million people in these areas are without adequate health care. While an estimated 4,314 Corps physicians are needed to serve in the 1,925 HMSA's across the nation, the Administration proposes a field service budget reduced by half from the FY 1989 level. Congress should provide ample funding for administering the Corps and reject the other imprudent proposal in the Administration's budget to provide no funds for loan repayment at the federal level. Downsizing the national loan repayment program in favor of the less efficient state grants program will only serve to diminish recruitment efforts and further undermine the capacity of the Corps to meet the challenge of the nation's underserved.

The AAMC regrets that time constraints limit the opportunity to endorse other important health programs under the Subcommittee's jurisdiction.

Senator **Burdick**. When you refer to your numbers, how do they compare with last year's numbers?

Dr. **Clawson**. The numbers that we are requesting? The numbers we are requesting are significantly up from last year's figures in all categories, but they are not up anywhere near what the coalition really believes is appropriate.

Senator **Burdick**. According to my records here, the Bush recommendation is $7.5 billion.

Dr. **Clawson**. That is correct.

Senator **Burdick**. In 1989, it is $7.2 billion, and you are in here with $8.4 billion.

Dr. **Clawson**. Yes, sir; that is what the ad hoc coalition has actually scaled down to. That does include, of course——

Senator **Burdick**. A $900 million increase?

Dr. **Clawson**. Yes, sir; we believe that is a very good investment at this particular point in time. You have heard testimony about the needs for advancing AIDS research. This has only $1.6 billion in it for AIDS research, and so I do hope that we can get all the support we can from the committee.

Senator **Burdick**. I asked a former witness this question, and you may not have been in the committee room. How do we avoid duplication of research, particularly in the AIDS Program? There are about 40 or 50 requests here from various organizations. How do we avoid overlapping and so forth?

Dr. **Clawson**. I think most of the requests that I have heard are in support of funding through the National Institutes of Health, and I think if that is properly managed we will avoid unnecessary duplication of research. In research, you never know where the answer is going to spring up, so some seeming duplication in well-established laboratories is really not duplication in the research effort because you never know who is going to get the breakthrough from what may seem to be——

Senator **Burdick**. I understand that perfectly. I also understand that we have a little thing called a budget.

Dr. **Clawson**. Yes, sir.

Senator **Burdick**. Thank you very much.

Dr. **Clawson**. Thank you. We appreciate it.

STATEMENT OF JAN TOWERS, PH.D., AMERICAN ACADEMY OF NURSE PRACTITIONERS

Senator **Burdick**. Jan Towers, Ph.D., American Academy of Nurse Practitioners.

Welcome to the committee.

Dr. **Towers**. Good morning.

Senator **Burdick**. Good morning.

Dr. **Towers**. My name is Jan Towers. I am president of the American Academy of Nurse Practitioners, and I function clinically as a clinician in a migrant health program in rural central Pennsylvania. I am here on behalf of the American Academy of Nurse Practitioners, a national organization representing nurse practitioners from all specialties.

I am here on their behalf to request that the Appropriations Committee, in light of the current nursing shortage, fully fund the authorization approved by Congress in the Nursing Shortage Reduction and Education Extension Act of 1988.

The need to fund nursing education programs is more imperative at this time than it has been in many years. I just returned from a meeting of the National Rural Health Association which only reinforces the fact that the nursing shortage is being felt not only in large urban areas but also in the rural and semirural areas of our country.

The current health needs of our rural populations are profound. I do not need to tell you of their higher concentrations of children under the age of 18 as well as adults over the age of 65, nor do I need to review with you the higher levels of poverty, higher levels of maternal and infant mortality, higher rates of chronic disease in urban areas of the country that have been found in these areas.

What I do want to talk to and to call to your attention and to call to the attention of the Appropriations Committee is that the nurse practitioners are needed to provide primary care to mothers and children as well as the elderly in these areas.

In preliminary data from the recently completed national survey conducted by the academy, seminurse practitioners were the major nurse practitioner providers in rural areas, followed by pediatric and women's health practitioners. These providers are needed everywhere. The care they provide is high quality, cost effective, and specific to the needs of the high risk populations that they serve.

I would add that the need for funding becomes more acute when one considers the future needs of the populations of this country. By the year 2000, the percentages of the population most in need of health care, the poor and the elderly, will have increased substantially. I will not go through the documentary figures, but we have those here.

Nurses are the major health care providers for these populations in both acute and ambulatory care settings. For this reason, funding needs exist for both entry and advanced level nurse education programs if there is to be any impact on health care for the above populations both now and in the future.

At the current time, demand for nurse practitioners outstrips their availability at a rate greater than three to one. As increased emphasis is placed on the provision of quality cost effective health care to all people in this country, the demand for health care providers such as nurse practitioners must increase if any attempt at all is to be made to provide accessible health care at more cost effective levels.

Over 400 studies have been conducted to evaluate the quality of care provided by nurse practitioners. Many of these studies have examined the issues of cost effectiveness as it relates to nurse practitioner practice. When given an opportunity, nurse practitioners charge less for their services. Cost savings measured through the reduction of patient hospital days among patients in practice settings using nurse practitioners have also been demonstrated in a variety of studies.

Record and Denton in their investigations calculate savings of $300 million to $1 billion per year if nurse practitioners were used to provide the services they are qualified to provide. Add to this the reduced cost for preparing nurse practitioners, 76 percent less than physicians and 14 percent less than physician assistants, and one can only conclude that the proposed legislative investment in the preparation of nurse practitioners is a good one. Indeed, one may even speculate that perhaps the larger sum should be allotted in the face of these returns.

Nurses and nurse practitioners are particularly well prepared to serve the underserved and the indigent. Large segments of our nursing curriculums are devoted to helping students to understand and implement care in settings among patients and clients with limited resources, financial and otherwise. The majority of nurse practitioners work for some, if not all, of their professional lives among the poor and the underserved. Again, we have statistics related to that.

Nurses do not need to be forced into these rules, nor do they need large financial incentives to keep them there. They do need to have opportunities to be prepared to practice in these areas, the ability to practice in a manner fitting their advanced education, and an equal opportunity to receive direct reimbursement for their services, however.

Based on this data, we conclude that the funding level authorized in the Nursing Shortage Reduction and Education Extension Act of 1988 are necessary if any attempt is to be made to deal constructively with the current and future health care needs of the people of this country as well as the shortage of nurse manpower both now and in the future.

PREPARED STATEMENT

We would encourage you to appropriate funding of the currently authorized programs at the authorized level of $107 million. We thank you for your efforts on our behalf in the past and in the future.

[The statement follows:]

STATEMENT OF JAN TOWERS

My name is Jan Towers. I am here in behalf of the American Academy of Nurse Practitioners a national organization representing nurse practitioners from all specialties. I am here on their behalf to request that the Appropriations committee, in light of the current nursing shortage, fully fund the authorizations approved by Congress in the Nursing Shortage Reduction and Education Extension Act of 1988.

The need to fund nursing education programs is more imperative at this time than it has been in many years. The nursing shortage is being felt not only in large urban areas, but also in the rural and semirural areas of our country. The current health needs of our rural populations are profound. These groups of people have been found to have higher concentrations of children under the age of 18 as well as adults over the age of 65. They have higher levels of poverty, higher levels of maternal and infant mortality, and higher rates of chronic disease than urban areas of the country (1) Nurse Practitioners are needed to provide primary care to mothers and children as well as the elderly in these areas. In preliminary data from the recently completed national survey conducted by the American Academy of Nurse Practitioners, Family nurse practitioners (56%) were the major nurse practitioner providers in rural areas followed by pediatric and women's health nurse practitioners (2). These providers are needed everywhere, but particularly in areas unable to attract and retain physician providers. The care they provide is high quality, cost effective and specific to the needs of the high risk populations that they serve.

The need for funding becomes more acute when one considers the future health needs of the population of this country. By the year 2000 the percentages of the population most in need of health care ie. the poor and the elderly, will have increased substantially. It is estimated that the elderly population alone will comprise thirteen percent of the total population (3). Current estimates identify the poverty rates among the elderly at twelve percent, those age 85 and over having double the rate (21%) as those age 65 to 74.(4) Another seventeen percent have been estimated to be among the near poor (5). The rates among minority populations are the highest. In addition, it has been estimated that twenty percent of the children in this country are poor (6).

Nurses are the major health care providers for these populations in both acute and ambulatory care settings. For this reason, funding needs exist for both entry and advanced level nursing education programs if there is to be any impact on health care for the above populations both now and in the future.

There are no quick cures for the shortage problem facing the nursing profession. Nurse practitioners view with great concern the potential shrinking of the pool which produces candidates for much needed advanced practice roles.

At the current time, the demand for nurse practitioners outstrips their availability at a rate greater than three to one. As increased emphasis is placed on the provision of quality cost effective health care to all people in this country, the demand for health care providers such as nurse practitioners must increase if any attempt to provide accessable health care at more cost effective levels is to be made.

Over 400 studies have been conducted to evaluate the quality of care provided by nurse practitioners. Many of those studies have examined the issue of cost effectiveness as it relates to nurse practitioner practice. Preliminary data from the national survey conducted by the American Academy of Nurse Practitioners indicate that nurse practitioner charges for services are significantly lower than those charged by physicians in their settings. (7) Studies demonstrating similar findings are listed in the attached bibliography.

Cost savings measured through the reduction of patient hospital days among patients in practice settings using nurse practitioners have also been demonstrated in these studies.(8) Record (9) and Denton (10) in their investigations, calculate savings of $300,000,000 to $1,000,000,000 per year if nurse practitioners were used to provide the services they are qualified to provide. Add to this the reduced cost for preparing nurse practitioners (76% less than physicians and 14% less than physician assistants) (11) and one can only conclude that the proposed legislative investment in the preparation of nurse practitioners is a good one. Indeed, one may even speculate that perhaps a larger sum should be allotted in the face of these returns.

Nurses and nurse practitioners are particularly well prepared to serve the underserved and the indigent.. Large segments of our nursing curriculums are devoted to helping students to understand and implement care in settings and among patients and clients with limited resources-financial and otherwise. The majority of nurse practitioners work for some, if not all their professional lives among the poor and underserved. In the previously mentioned survey of the American Academy of Nurse Practitioners an average of 65% of the patients seen by Family, Pediatric and Womens Health Nurse Practitioners have annual incomes of less than $15,000 per year. Gerontologic Nurse Practitioners report that 81% of the people they see are in that income bracket. Eighty-three percent of the nurse practitioners in rural areas see children under the age of 12; seventy three percent see people over the age of 65. Likewise, in urban areas, forty percent of the nurse practitioners work with children under the age of twelve, and fifty two percent work with the elderly.(12)

Nurses don't need to be forced into these roles, nor do they need large financial incentives to keep them there. They do need to have opportunities to be prepared to practice in these areas, the ability to practice in a manner fitting their advanced education and an equal opportunity to receive direct reimbursement for their services, however.

Based on this data we conclude that the funding level authorized in the Nursing Shortage Reduction and Education Extension Act of 1988 are necessary if any attempt is to be made to deal constructively with the current and future health care needs of the people of this country as well as the shortage of nurse manpower both now and in the future.

We would encourage you to appropriate funding of the currently authorized programs at the authorized level of $107,000,000. We thank you for your efforts in our behalf in the past and in the future.

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Senator BURDICK. What you present us is quite a problem. You are asking for $107.9 million. For fiscal year 1989, it was $55.5 million.

Dr. TOWERS. That is correct.

Senator BURDICK. The man in the White House says zero.

Dr. TOWERS. Yes; we talked with some of the people related to the man in the White House, and we understand that he did not really mean zero. [Laughter.]

Senator BURDICK. Would you tell that fellow to get in communication with us?

Dr. TOWERS. We will certainly work on that.

Senator BURDICK. Tell him to send an amendment down. That would be fine.

Dr. TOWERS. The other thing that I would point out, too, is that 15 years ago the amount that was authorized and appropriated for nursing education was considerably higher than it is now, so that this is still very small compared to what we have had in the past, and in light of the current shortage, I think, it behooves us to look at this even though we are asking for more.

Senator BURDICK. Well, I hope there is some way you can have a little visit with the President, because that is quite a roadblock.

Dr. TOWERS. We will work on it.

Senator BURDICK. Thank you.

Dr. TOWERS. Thank you.

STATEMENT OF KATHERINE McCARTER, PRESIDENT, COALITION FOR HEALTH FUNDING

ACCOMPANIED BY JOHN FRIEL, EXECUTIVE DIRECTOR, COALITION FOR HEALTH FUNDING

Senator BURDICK. Katherine McCarter, president, Coalition for Health Funding.

Maybe you can throw some light on this funding business I have been talking about.

Ms. MCCARTER. We will try.

Senator, I am Katherine McCarter. I am associate executive director of the American Public Health Association, but I am here today as president of the Coalition for Health Funding. With me is

John Friel, who is the executive director of the Coalition for Health Funding.

The coalition is composed of approximately 58 national organizations representing over 10 million people in health professional organizations, voluntary health agencies, consumers and providers of health care, and the institutions that train health professionals.

We would like to start our testimony by thanking you and the other members of this subcommittee for the very strong support that they have given in the past to health programs and particularly to the programs of the Public Health Service.

As you know, these programs range in mission and character from biomedical and behavioral research to assistance for students in all areas of health professions education to childhood immunizations, and they are the backbone of our system of health promotion and disease prevention and treatment.

In the past, the subcommittee has seen fit to approve significantly higher levels of funding for these programs than the administration has requested, and we hope that you will do so again.

The Coalition for Health Funding believes that in determining the appropriate level of funding for the Public Health Service, one must begin with the current service's budget. The idea that society can do less next year in the effort to eradicate cancer, cardiovascular diseases and stroke, and AIDS, less for the sick and elderly, less to train health professionals, less to understand and treat mental illnesses, lung disease and other scourges, and less to prevent injuries and childhood illnesses is just unrealistic. At worst, it is a poor and inaccurate reflection of an enlightened and caring society.

After years of pressure on spending and hiring coupled with the rise of new age diseases in an aging population, there really is no fat left in the Public Health Service budget. We know, however, that just maintaining last year's funding is not enough. Our budget recommendation will allow the initiation of critical and important new or expanded initiatives.

Mr. Chairman, the coalition's written testimony contains our specific recommendation for a total of $16.9 billion for 1990 for the various Public Health Service entities. The chart on the first page of our testimony displays our specific recommendations for the Public Health Service agencies, including the National Institutes of Health, ADAMHA, the Centers for Disease Control, the Health Resources and Services Administration, the Office of the Assistant Secretary for Health, FDA, and the Indian Health Service.

In addition, in our written testimony we enumerate the important programs and the new initiatives which we believe that this funding can accomplish.

You have talked a lot about coordination, and I want you to know that our specific recommendations have been coordinated with a variety of other coalitions who deal with some of the specifics of the Public Health Service budget. For instance, we have enlisted the aid and support of our colleagues in the Ad Hoc Group for Medical Research, the Centers for Disease Control Coalition, the National Health Council, the National Organizations Responding to AIDS, and others. In all, we estimate that almost 200 national organizations are supportive of our recommended funding levels.

In developing our recommendations, Senator, we have attempted to apply our collective professional judgment about the amounts that can be well utilized by these agencies in fulfilling their statutory missions and in meeting the challenges of today's society.

PREPARED STATEMENT

We would like to thank you again for the opportunity to submit our written comments to this subcommittee and to thank you for your past support for the programs administered by the Public Health Service.

[The statement follows:]

STATEMENT OF KATHERINE McCARTER

SUMMARY OF COALITION FOR HEALTH FUNDING RECOMMENDED FY'90 APPROPRIATIONS FOR THE U.S. PUBLIC HEALTH SERVICE (PHS)

(in millions)	FY'89 Comparable	FY'90 Current Services	FY'90 CHF Recommended
NIH	7,101	7,958	8,416
HRSA	1,460	1,514	1,882
ADAMHA	1,759	1,884	2,414
CDC	979	1,028	1,579
OASH	313	348.5	411.5
FDA	537	575	690
IHS	1,081	1,148	1,528
TOTAL	13,230	14,455.5	16,900.5

Mr. Chairman, and members of the Subcommittee, my name is Katherine McCarter. I am President of the Coalition for Health Funding.

The Coalition for Health Funding is composed of some 38 national health organizations representing over 10 million people in voluntary health agencies, consumers and providers of health services, and the institutions that train health professionals and others. Attached to my testimony is a list of the Coalition members. The thread that unites these diverse groups is an overriding concern and support for the research and service and training programs at the U.S. Public Health Service (PHS). The primary objective of the Coalition is to emphasize and protect the many and varied programs, projects, and activities of the PHS that are of crucial importance to a strong and vital health care system in the United States.

Mr. Chairman, I appear before you today to discuss the Coalition's serious concerns with the Administration's budget request for the PHS for Fiscal Year 1990. Preliminarily, I would like to express gratitude for the support that the members of this Subcommittee have shown for the PHS's programs. These programs, which range in mission and character from biomedical and behavioral research to assistance for students in all areas of health professions education, are the backbone of our system of health promotion and disease prevention and treatment. In past years, this Subcommittee has seen fit to approve significantly higher levels of funding for the PHS than the Administration has requested. We hope that you will do so again. We recognize that, as in years past, there is more demand than there are resources. However, we believe that there can be no more deserving cause than protection of the health of our nation by building upon the enormous strides being made in the areas of biomedical research and training. These vital programs will suffer, however, if we do not act now to increase the level of discretionary health spending to an acceptable level.

AIDS

The Coalition applauds the President's increased awareness and commitment to the AIDS epidemic. We, as a nation, must do everything we can to combat the AIDS crisis. Efforts are underway throughout the Public Health Service to do so: The National Institutes of Health (NIH) is vigorously pursuing treatments and a cure for this disease; the Alcohol, Drug Abuse and Mental Health Administration (ADAMHA) is studying the behavioral aspects of the disease; the Centers for Disease Control has been the source of epidemiological data by which the spread of AIDS has been tracked and monitored, and has been in the forefront of the PHS's efforts to institute public health measures to halt the progress of AIDS among high risk populations; and the Health Resources and Services Administration has also allocated some resources to train health professionals to understand and care for patients afflicted by AIDS.

This unprecedented response by a variety of PHS agencies to the AIDS emergency would not have been possible if Congress had not maintained these programs at a level of funding that allowed them to remain fully responsive. We recommend that $2 billion be devoted to AIDS research in FY 1990.

COALITION FOR HEALTH FUNDING RECOMMENDATION

The Coalition for Health Funding believes that in determining the appropriate level of funding for the Public Health Service, one must begin with the current services budget. The idea that society can do less next year in the effort to eradicate cancer, cardiovascular diseases and stroke, and AIDS, less for the sick elderly, less to train health professionals and managers, less to understand and treat mental illness, lung disease, cystic fibrosis and other scourges, is at best unrealistic. At worst, it is a poor and inaccurate reflection of an enlightened and caring society. After years of pressure on spending and hiring, coupled with the rise of new age diseases and an aging population, there is no fat left in the PHS budget.

The Coalition thinks it is extremely important for Congress to avoid the short term "solution" to the AIDS crisis of rechanneling research and healthcare dollars from other areas to AIDS. The AIDS epidemic is a calamity of overwhelming proportions requiring a sustained and coordinated response. The appearance of AIDS, however, has not in any way obviated the need to maintain and expand our commitment to the cure of other deadly diseases, such as cancer, cardiovascular disease, and stroke.

The $2.8 billion requested by the Coalition beyond the current services budget would fund the following new or expanded initiatives:

NATIONAL INSTITUTES OF HEALTH

FY 1989 Comparable	FY 1990 Current Services	FY 1990 CHF Recommended
7,101	7,958	8,416

o The CHF recommendation would enable the NIH to support approximately 11,800 research trainees -- a 5% increase over FY'88 -- and provide the necessary funds to cover the proposed increase in stipends.

- NIH could support 6427 competing research project grants, allowing funding of a very modest one-third of approved applications -- those which are deemed through peer review to have potential for providing important scientific information. The total number of research grants would be increased by 1000.
- NIH programs generally would be permitted an inflation increase of 5.6%, reflecting the projected increase in the Biomedical Research and Development Price Index.

CENTERS FOR DISEASE CONTROL

FY 1989 Comparable	FY 1990 Current Services	FY 1990 CHF Recommended
979	1,028	1,579

- The CHF recommendation would allow CDC to continue the critical program of child immunization at an appropriate level, and would provide needed funds for the CDC vaccine stockpile.
- Implementation of chronic disease programming in areas such as breast and cervical cancer and diabetes would be possible.
- The injury control program, which addresses the leading cause of death and disability of persons up to age 44, would expand its capacity to fund injury research and control programs.
- Additional funds for the control of sexually transmitted disease would be available.
- Funds would be restored for the National Institute on Occupational Safety and Health (NIOSH) research and training program.
- Enhancement of the technical diagnostic capabilities in rare infectious diseases, implementation of a new program in Lyme disease prevention and control, implementation of the recently developed tuberculosis

elimination plan for America, and screening and appropriate immunization of pregnant women and their offspring for hepatitis B infection would be possible.

- Funding for the Preventive Health Services Block Grant would be provided at an appropriate level.

HEALTH RESOURCES AND SERVICES ADMINISTRATION

FY 1989 Comparable	FY 1990 Current Services	FY 1990 CHF Recommended
1,460	1,514	1,882

- The CHF recommendation would provide adequate levels of funding for HRSA programs, including those aimed at educating ethnically and economically diverse health professionals who will be able to meet the health care challenges of tomorrow - including serving patients with special needs, such as the handicapped, AIDS sufferers, the medically compromised elderly, and those in underserved ares.
- Continuation of the National Health Service Corps, a program of vital importance to underserved rural and inner city areas, would be possible.
- Increases for inflation and modest growth would be possible in programs supported under the Maternal and Child Health (MCH) block grant, a program of proven value for the future health of American citizens.
- Increases for inflation and modest expansion in the Community Health Centers program, one of the principal agencies in the effort to provide health care services to the homeless, the uninsured, and others of our poorest citizens who have no other access to health care.
- Continuation and modest expansion of programs of financial aid to disadvantaged health professions

students, and institutional support for primary care training programs, could be supported.

- New efforts could be undertaken in training in geriatrics and care of the elderly, and in compensating for presently unreimbursed costs of caring for AIDS patients, such as costs associated with providing oral health care.

ALCOHOL, DRUG ABUSE AND MENTAL HEALTH ADMINISTRATION

FY 1989 Comparable	FY 1990 Current Services	FY 1990 CHF Recommended
1,759	1,884	2,414

- The CHF recommendation would permit a serious effort to cope with the grave national burdens of mental disorders, alcoholism and drug abuse, which directly afflict 30 to 45 million Americans and cost $215 billion (in 1984 dollars) in medical costs and lost productivity.
- Continuation of support for the National Plan for Schizophrenia Research, a project endorsed in 1987 by the Senate Appropriations Committee would be possible.
- Needed support for the "Decade of the Brain" Neurosciences Research Plan, aimed at exploring neuroscientific approaches to mental illness, would be available.
- Needed inflation adjustments for all ADAMHA programs would be possible.

OTHER

- Adjustments for inflation and modest growth in such vital programs as the Indian Health Service, the Food and Drug Administration, Family Planning and others would be possible under the CHF budget recommendation.

CONCLUSION

Mr. Chairman, members of the Committee, thank you once again for the opportunity to address the Subcommittee today. Thank you also for your steadfast support for the programs administered by the Public Health Service.

COALITION FOR HEALTH FUNDING MEMBERSHIP

American Academy of Pediatrics
American Academy of Physician Assistants
American Association of Colleges of Nursing
American Association of Colleges of Osteopathic Medicine
American Association of Colleges of Pharmacy
American Association of Dental Research
American Association of Dental Schools
American Association of University Affiliated Programs
American College of Rheumatology
American Dental Association
American Heart Association
American Lung Association
American Nurses Association
American Optometric Association
American Psychiatric Association
American Public Health Association
American Psychological Association
Association of American Medical Colleges
Association of American Universities
Association of American Veterinary Medical Colleges
Association of Chiropractic Colleges
Association of Schools of Public Health
Association of State and Territorial Health Officials
Association of University Programs in Health Administration
Citizens for the Treatment of High Blood Pressure
Cystic Fibrosis Foundation
Infectious Diseases Society of America
March of Dimes Birth Defects Foundation
National Association of Childrens Hospitals and Related Institutions
National Association of Community Health Centers
National Association for Music Therapy
National Association of State University and Land Grant Colleges
National Family Planning & Reproductive Health Association
National Health Education Committee
National League for Nursing
National Student Nurses Association
Planned Parenthood Federation of America
Society for Investigative Dermatology

Senator **Burdick**. Well, to make a long story short, you are asking for an increase of $3.7 billion for all the Public Health Service agencies?

Ms. **McCarter**. Yes, sir.

Senator **Burdick**. Last year we were pretty good to you. The subcommittee total last year was $1.7 billion for all programs.

Ms. **McCarter**. We are very appreciative of the support that we have received in the past from this subcommittee, but we do believe that there are new initiatives, new programs, and new challenges that we have been unable to meet in this country and are still waiting for us to deal with, AIDS being just one of the ones that we have heard about this morning, but all the other areas that the Public Health Service is involved in have important missions that are yet to be met.

I hope in our testimony we have elaborated some of those areas that we think need special attention.

Senator **Burdick**. The committee will do its best as we have in the past.

Ms. **McCarter**. We count on you, as always, Senator.

Senator **Burdick**. Thank you.

Ms. **McCarter**. Thank you.

STATEMENT OF CHARLES R. MODICA, J.D., CHANCELLOR, ST. GEORGE'S UNIVERSITY SCHOOL OF MEDICINE

Senator **Burdick**. Our next witness is Charles Modica, Juris Doctor, chancellor, St. George's University School of Medicine.

Where is St. George's School of Medicine?

Dr. **Modica**. In Grenada, sir. I think you have heard of us.

Mr. Chairman, I am very pleased to appear before you today to discuss student financial assistance and issues related to health professions as they affect foreign medical students and graduates.

The President's budget proposal for fiscal year 1990 for student aid programs has not significantly improved over past years. The demand in genuine need for Federal resources for students seeking educational assistance continues to be significant. We are encouraged that some additional resources have been recommended for guaranteed student loans, but the need continues to grow. This program is one of the few Federal student aid programs in which U.S. students attending foreign medical schools such as St. George's are able to participate in.

Since St. George's was founded in 1976, nearly 1,400 students have graduated with degrees in medicine. Many of these students have returned to the United States to practice in underserved areas, often in inner city area teaching hospitals that treat great numbers of lower income and indigent patient populations.

In fact, 80 to 90 percent of residency positions are filled by graduates of foreign medical schools in the inner city areas. There would be a significant problem in handling the patient load in many of these hospitals if not for residency slots being filled by eager graduates of non-U.S. schools such as St. George's.

This is particularly important in light of the testimony we have heard today on the AIDS virus. These same hospitals in these inner city areas that are staffed primarily by foreign medical graduates in residency and staff positions treat almost the entire load of AIDS patients in this country today.

PREPARED STATEMENT

We, therefore, are requesting that residency funding for foreign graduates continue to be maintained and that student loans for foreign medical schools continue to be maintained.

We also request that the additional $1 million for the COGME group that was established by Congress be continued so that they can continue to do their work regarding the projections of future medical and other resources in coming years.

Thank you for the opportunity to present the statement to your subcommittee.

[The statement follows:]

STATEMENT OF CHARLES R. MODICA

Mr. Chairman and members of the Subcommittee, I am very pleased to appear before you today to discuss student financial assistance and issues related to health professions.

Student Aid

The President's budget proposal for FY'90 for student aid programs is not significantly improved over past years. The demand and genuine need for federal resources for students seeking educational assistance continues to be significant. We are encouraged that some additional resources have been recommended for Guaranteed Student Loans but the need continues to grow. This program is one of the few federal student aid programs in which U.S. students attending St. George's are able to participate. This is possible because, Mr. Chairman, during the Higher Education Act reauthorization of 1986, Congress provided a special GSL inclusion for students attending foreign medical schools that have a pass rate of 45% or higher in the examination administered by the Education Commission for Foreign Medical Graduates (ECFMG). Under this inclusion, St. George's is the only Caribbean institution that qualifies, because of its comparatively high pass rate. Federal student aid programs should be available for U.S. students wherever they choose to attend school.

Health Professions Graduate Education

Since St. George's was founded in August of 1976, nearly 1200 students have graduated with degrees in medicine, many of whom returned to the United States to practice in underserved areas. Often in inner-city area teaching hospitals that treat great numbers of low-income and indigent patient populations, 80-90% of residency positions are filled by graduates of foreign medical schools. There would be a significant problem in handling the patient load in many of these hospitals if not for residency slots being filled by eager graduates from non-U.S. schools such as St. George's. The Journal of the American Medical Association, in its January 18, 1985 issue, reported that St. George's University School of Medicine had the highest initial pass rate of all the leading foreign medical schools in the world on the U.S. Qualifying Examination (the ECFMG). As each class at St. George's finishes its second year of medical education, approximately one-third of that class transfers to U.S. medical schools to complete their education.

I would like to advise you of a significant development that is central to the continued progress of our school as a recognized producer of quality medical graduates. The New York State Department of Education has reached a decision that approves the placement of third and fourth year students from St. George's to begin clinical clerkships at several of New York's teaching hospitals. About 60 of our third and fourth year medical students are engaged in two-year clerkships at Brooklyn Hospital, Methodist Hospital, and Coney Island Hospital, in Brooklyn.

The approval by New York, along with a similar 1985 decision by New Jersey, clearly demonstrates the confidence placed in St. George's by independent State Education Departments after on-sight reviews of our campuses. The approval by New York makes St. George's the only foreign school offering medical education in English that has an approved campus in New York State.

In 1986, Congress established the Council on Graduate Medical Education (COGME), an advisory body comprised of a representative sample of experts in medical education. The Council on Graduate Medical Education was asked to issue a report to the Secretary of HHS and the Congress to advise them how they should deal with issues related to Graduate Medical Education from the standpoint of public policy. This is the first time in almost a decade (since GMENAC) that the issue of Graduate Medical Education has been studied thoroughly and extensively by non-biased experts in the field.

The conclusions and recommendations of the Council were released to Congress in July of last year. The recommendations and conclusions of the Subcommittee on Foreign Medical Graduates include:

- The same National Board of Medical Examiners (NBME) exam should be administered to foreign or U.S. medical graduates if that is the only means to insure comparability of the exams; FMGMES vs. NBME.

- Foreign medical graduates and U.S. medical graduates should not be treated separately and unequally, and that selection into graduate medical education should be based on individual competence, not on group association.

- If the government has no rational basis for denying public funds for graduates of foreign medical schools, it could be considered constitutionally discriminatory.

Mr. Chairman, frankly, we expected a witch hunt by the Council on Graduate Medical Education in a campaign to wipe out opportunities for graduates of foreign medical schools. Instead, the Council made a very comprehensive and complete review of all of the issues related to foreign medical graduates and has developed conclusions and recommendations similar to what we have been stressing for several years. The Council on Graduate

Medical Education has now added important credibility to these arguments, that, I believe, should be carefully considered.

The current and ongoing activities of the Council on Graduate Medical Education are of great importance to the development of sanguine policy for the future for a host of Graduate Medical Education issues. Financing, specialty differentials, the underrepresentation of minorities in medicine, foreign medical graduate equality, and geographic maldistribution of physicians are all issues that warrant the continued support of activities of the Council on Graduate Medical Education.

Similar to the Physician Payment Review Commission and the Prospective Payment Assessment- Commission, we believe that it would be beneficial to provide a distinct appropriation for COGME to address a number of critical projects that are not within their current means. The modest investment of $1 million for COGME would easily pay dividends in savings in Graduate Medical Education, and by improving our nation's health care and professional delivery system.

Thank you for the opportunity to present this statement to your Subcommittee. We would be very pleased to work with you on these important, complex issues.

STATEMENT OF JAMES G. JONES, M.D., PRESIDENT, AMERICAN ACADEMY OF FAMILY PHYSICIANS

Senator **Burdick**. James G. Jones, M.D., president, American Academy of Family Physicians.

Welcome to the committee.

Dr. **Jones**. Good morning, Senator Burdick.

Mr. Chairman, I am Jim Jones, a country doctor from North Carolina who this year has the privilege of serving as the president of the American Academy of Family Physicians. I am here today to thank you, sir, to testify on behalf of our 65,000 members. I hope that what I will be able to say to you today will be of some help to you as you frame an appropriations bill to continue the support of our educational programs in family medicine. You have been good to us in the past, and we deeply appreciate the support of the subcommittee.

The ultimate goal of why we believe that the subcommittee should favorably consider our request for family practice is that we believe that through family physicians we have the best chance for providing access to quality health care for the American people.

Family physicians, as you well know, Senator, are uniquely qualified because of the wide range of patients we care for, the geriatric patients all the way back to the children. Our physicians also serve primarily in rural areas and in the inner city areas where over and over again you have heard that there are severe shortages.

You have heard already from the report from the Council on Graduate Medical Education this year which requests and points out that funding for family practice education ought to continue because there are still significant shortages. It is kind of paradoxical, Mr. Chairman, that while there is perhaps an oversupply of physicians in the United States, family physicians that are badly needed and underrepresented continue to need the assistance of training programs like this if we are ever going to meet the demands for family doctors.

We have two unique problems. There is not a great interest in medical students in choosing careers in family medicine because of the reimbursement schedule that we hope Congress is also going to address this year.

In addition to that, one-third of our members we are going to lose through retirement and death because they are over 55 years old.

So we face those unique problems, and we appreciate the support of your subcommittee in the past and hope that you will continue that.

As the lights are about to change, let me mention to you that we also strongly support the $1 million appropriation which has been requested by COGME. We think that COGME has and will continue to provide you with very sound and fundamental statistical bases on which you can judge what the physician supply will be in the future.

PREPARED STATEMENT

We support them because we are confident that it will show that America needs more family physicians. We would understand even with your budget constraints that while we have authorization for more requests, we would request at least the funding that we are presently funded at because without your support, we are very fearful that our programs will not continue to turn out the numbers of family physicians that are needed by this country.

I would be happy to answer any questions for you, sir.

[The statement follows:]

STATEMENT OF JAMES G. JONES

I am James G. Jones, M.D., President of the American Academy of Family Physicians. The Academy is the national medical specialty society representing over 65,000 practicing family physicians, family practice residents and medical students. I am pleased to have the opportunity to appear before this subcommittee to discuss with you appropriations for Fiscal Year 1990 for family practice education. I hope that our testimony will help you in shaping an appropriations bill that continues financial support of family practice programs with the ultimate goal of improving access to health care by the American people.

The Federal Role:

Last year with the support of this Subcommittee, Congress appropriated $34.980 million for family practice residency training (Section 786 of the Public Health Service Act) and $6.6 million for departments of family medicine within medical schools (Section 780). We deeply appreciate your recognition of the positive contribution of the specialty of family practice to the nation's health care.

The family practice training funds provide grant support for targeted projects -- to train residents to become family physicians, to develop faculty in the specialty, to create and strengthen departments of family medicine within medical schools to ensure that students are exposed to family practice as a viable career choice. Graduates of these programs serve the medically needy in remote rural areas as well as improverished inner-city areas. Care of the geriatric and the pediatric patient alike is integral to family practice. The ultimate goal of the funds is to help produce family physicians who will enter practice, and provide continuous, cost-effective primary care to patients.

Unique Challenges Facing Family Practice:

The Council on Graduate Medical Education (COGME), in its first report to Congress, concluded that shortages continue in the specialty of family practice. It is interesting to note that the United States has a smaller proportion of primary care physicians than any other developed country (13 percent of U.S. physicians are family physicians as compared to 53 percent general/family physicians in Canada). While the demand for family physicians is high and growing, the supply is not keeping pace. This is for several reasons. COGME noted that reimbursement to physicians in primary care specialties tends to be lower than for procedurally-oriented specialties, making primary care a much less attractive career choice for medical students. This dynamic is evident as family practice has experienced a slight decline in the national residency match for the past two years. This is accompanied by a projected high rate of retirement from practice by the more than one-third of family physicians/general practitioners age 55 and older. These two trends will reduce the number of family physicians in practice.

In addition, family practice residency programs face difficult and unique financial constraints. Over two thirds of family practice residency programs are located in community hospitals, rather than in traditional tertiary medical centers. In addition to the community hospitals, family practice residency programs are exploring affiliation with community health centers, migrant health centers and free clinics. Location in non-traditional training sites, coupled with an ambulatory-based training model which emphasizes training in a family practice center to simulate practice in a physician's office, provide these residency programs with significant financial challenges.

Under the Medicare program higher reimbursements are made to faculty and to teaching hospitals for procedural services and inpatient care. An ambulatory-based, primary care discipline such as family practice therefore produces significantly less revenues for educational programs than inpatient-based, procedurally oriented disciplines.

The federal grants help to offset some of this disadvantage experienced by family practice education programs. However, as federal support has plateaued over the past several years, so has growth in family practice education. Both the number of family practice residency programs, and the number of residents in these programs have leveled off. Currently 7,279 residents are enrolled in 381 approved residency training programs throughout the country. These numbers have been fairly stable for the past seven years, after experiencing tremendous growth from the inception of the specialty in 1969 through 1982.

COGME explicitly recommended expansion of existing Title VII grants for training in primary care. The Academy concurs with that recommendation. Continued federal support is essential to sustain the progress made to date. Enhanced programatic efforts will require an additional federal commitment.

Funding for Council on Graduate Medical Education:

The American Academy of Family Physicians also supports an appropriation of $1 million for the Council on Graduate Medical Education, known as COGME. COGME was mandated by Congress to study and make recommendations on issues related to physician supply. It already has submitted a report to Congress, and has developed an ambitious research agenda for the coming year. Projected activities include study of the impact of underrepresented minorities in medicine, geographic distribution of physicians, financing medical education in ambulatory settings, and specialty-specific physician requirements modeling. However, we believe that COGME will need an appropriation if it is to achieve these goals in a complete and comprehensive manner. Federal policy should be based on sound, verifiable data. We believe with your help COGME can make a significant contribution to this subcommittee and others in Congress.

Summary:

The targeted federal investment in family practice training has helped address both geographic and specialty maldistribution of physicians services. While progress has been made, much remains to be done to achieve our mutual goal of assuring access to quality health care by the American people. Given the significant and growing demand for family physicians, the supply is inadequate and will remain so without specific action 1. to encourage medical students to select family practice as a career, 2. support development of faculty, and 3. provide assistance so that residency positions are available for interested students. Federal financial support is essential.

The authorization levels for support of family practice training programs would provide $7 million for departments and $40 million for residency programs. However, the American Academy of Family Physicians is cognizant of the budgetary constraints facing Congress. For this reason, we encourage this subcommittee to continue funding for family practice education through both Section 780 and Section 786 of the Public Health Service Act at current levels. We appreciate your support in the past and look forward to continuing to work with you on appropriations for Fiscal Year 1990.

Senator BURDICK. According to the figures I have here for family practice, in fiscal year 1989 it was $35 million. You are asking for $35 million?

Dr. JONES. For our residency program, sir, and some additional moneys for our departments of family medicine.

Senator BURDICK. Now, the departments are $6.6 million for 1989, and you are asking for the same thing, $6.6 million?

Dr. JONES. Yes, sir; and our appreciation of the tough job you have with the budget constraints——

Senator BURDICK. Just a minute. You have not heard the whole thing. The White House says zero.

Dr. JONES. I know that, sir.

Senator BURDICK. I am trying to find the disparity here.

Dr. JONES. We hope that you will correct the misjudgment in that regard, sir.

Senator BURDICK. Let us see. Council for Medical Education was nothing last year, but you are asking for $1 million?

Dr. JONES. Yes, sir; actually, we are just testifying in support of their request because COGME has just begun, as you heard earlier, to look at the supply issue of physicians in general in this country and the maldistribution of physicians. We support their work.

Senator BURDICK. Of course, the administration is against that, too.

Dr. JONES. We have heard that, sir.

Senator BURDICK. Well, the committee will do its best.

Dr. JONES. Thank you very much. You have been good to us in the past. Thank you.

STATEMENT OF DAVID RICHARDS, D.O., PRESIDENT, TEXAS COLLEGE OF OSTEOPATHIC MEDICINE, AMERICAN ASSOCIATION OF COLLEGES OF OSTEOPATHIC MEDICINE

Senator BURDICK. David Richards, president, Texas College of Osteopathic Medicine, American Association of Colleges of Osteopathic Medicine.

Welcome to the committee.

Mr. RICHARDS. Good morning, Senator. I am David M. Richards, D.O., formerly a country doctor and now president of Texas College of Osteopathic Medicine, but I am also here as the chairman elect of the board of governors of the American Association of Colleges of Osteopathic Medicine. I am pleased to present the views of AACOM in fiscal year 1990 funding for programs to support the education of health professionals under title 7.

We are again appreciative of your ongoing support. An important example of how effective these programs you fund can be is found in the Health Careers Opportunity Program. It is an essential part of our work to enhance health professions educational opportunities for disadvantaged and minority students. I am most pleased to report that through this grant we collectively were able to increase the first year enrollment of minority and disadvantaged students between the fall of 1987 and the fall of 1988 by a huge 64 percent.

In addition to this important recruitment program for minority and disadvantaged students, there are other areas in which the colleges and the Federal Government have forged a successful partnership. Among these are the education of primary care physicians, the care of the elderly and the delivery of health services in rural communities.

One of the missions of our college in Texas is to train primary care physicians. Four out of every five of our graduates have entered primary care, and nearly one-half of them practice in small Texas communities. Our efforts and similar efforts of other colleges are supported by Federal grants in family medicine training programs and general internal medicine.

Seven out of our 15 colleges also participate in area health education centers. This is an important program for us. Our colleges have a strong orientation toward rural health. In our college, they rotate through a rural clinic in Texas, combining services to patients with education in special needs of rural people.

The new rural interdisciplinary training programs in the Office of Rural Health Policy Research Centers are important to the success of the rural health mission.

Osteopathic medical schools are extensively involved in geriatric medicine. Federal programs to support geriatric departments and other geriatric training and educational activities are extremely important.

Many of our students report parental income of less than $30,000. Federal student assistance programs are critical to them. In my own school, 335 of 391 students receive Federal financial aid. The program is extremely important.

PREPARED STATEMENT

Senator, again on behalf of all of us at the AACOM, we thank you for your support that you have given us, and we urge your continuing endorsement of these activities to support full funding at the increased levels for 1988.

I would be pleased to answer any questions. Thank you.

[The statement follows:]

STATEMENT OF DAVID RICHARDS

My name is David M. Richards, D.O. I am President of the Texas College of Osteopathic Medicine (TCOM) in Fort Worth and I am also Chairman-elect of the Board of Governors of the American Association of Colleges of Osteopathic Medicine (AACOM). I am pleased to present the views of AACOM on Fiscal Year 1990 funding to support the education of health professionals.

I would like to address three areas in which the osteopathic colleges and the federal government have formed a successful partnership. These are the education of primary care physicians, the care of the elderly, and the delivery of health services in rural communities. Each is a major goal of the colleges and is supported by one or more health professions education grants under Title VII of the Public Health Service Act.

There continue to be shortages of primary care physicians. For example, fourteen Texas counties have no physician. Federal grant programs that support family medicine and general internal medicine training are invaluable to addressing the needs in these areas.

Several of our colleges, including my own in Texas, are dedicated to meeting the need for primary care physicians. Four out of five TCOM graduates have entered primary care and nearly half practice in smaller Texas communities. The Ohio University College of Osteopathic Medicine in Athens and the West Virginia School of Osteopathic School of Medicine in Lewisburg were both expressly charged by their state legislatures to train primary care osteopathic physicians to practice in the medically underserved areas of those states..

Osteopathic medical colleges have responded not only to the need for more primary care physicians, but also to the immediate health care needs within the communities where our schools are located. For example, federal family medicine grants have strengthened the ability of the Chicago College of Osteopathic Medicine to support the faculty and staff who work with the students in the college's extensive ambulatory clinic system. We need your support for these grant programs if we are to continue to be as effective in training primary care physicians to meet future medical needs.

Several of our schools have become key partners in Area Health Education Centers (AHEC). This important multi-disciplinary program helps our Ohio college, for example, fulfill its legislative mandate by providing medical care to the rural, underserved areas of southeastern Ohio. Other colleges also participate in AHEC grants. For example, the Southeastern College of Osteopathic Medicine in Florida provides medical services to migrant families through an AHEC.

Continued federal support of AHECs is essential. We ask for full funding of the AHEC program, including the newly authorized initiatives for border areas and areas with special needs. These new projects should receive their own support, not erode funding for ongoing AHECs.

The colleges of osteopathic medicine realize that providing individuals with the basic skills and interest in practicing in rural health is essential to solve the health needs of rural, underserved areas. At the Texas College of Osteopathic Medicine, students rotate through rural clinics in Justin and Godley, Texas, combining service to patients together with education in the special needs of rural people. Students may train with rural physicians located in small communities throughout Texas.

Because osteopathic medical colleges are often small, they must rely on the active participation of the federal government to keep these rural programs alive. Especially important is full funding of the new rural interdisciplinary training programs and the Office of Rural Health Policy's research centers.

My own college, TCOM, has integrated geriatrics into a number of the clinical courses. Between required and elective courses, our students receive extensive experience with geriatric patients. The twelve week ambulatory care rotation prepares our students to care for elderly patients in a variety of settings, especially in the nursing home. Other rotations of geriatric services assure that the graduate of the Texas College of Osteopathic Medicine has been well grounded in caring for the elderly patient.

With the increased aging population it is more and more important that programs of geriatric education be expanded, not reduced. Federal assistance is essential to develop geriatric departments at our schools and to support the programs now underway. We encourage the subcommittee to fully fund geriatric training and education programs in the Department of Health and Human Services.

Many of our senior students report parental income of less then $10,000 and some 40% come from families with incomes less than $30,000. Federal student assistance programs are critical to our students. AT TCOM, 335 students of our total 1988-1989 enrollment of 391 met the eligibility requirements for federal assistance programs and received financial aid.

The HEAL program is extremely important. As other federal student aid programs have become scarce, HEAL loans have become increasingly important. Thirty five percent of TCOM's eligible students receive loans under the HEAL program. Any reduction in loan guarantees could seriously affect the ability of many of our students, and students at other colleges of osteopathic medicine, to continue their education.

The Health Career Opportunities Program (HCOP) is an essential part of our schools' efforts to enhance the health professions educational opportunities of disadvantaged and minority students. Through the federally funded programs of the colleges of osteopathic medicine and AACOM, the first year enrollment of minority and disadvantaged students at our schools increased 64% between the Fall of 1987 and the Fall of 1988. The summer enrichment program managed by AACOM for about 90 college and high school students interested in a health professions career is held at TCOM each summer.

Mr. Chairman, the members of AACOM deeply appreciate the support this subcommittee has given to these very important programs. That support has contributed to our efforts to produce primary care physicians who will practice in small communities, meeting the needs of America's elderly, particularly in rural areas. We urge your continuing endorsement of these programs and support for the fullest possible funding.

Senator **Burdick.** I notice in the facts I have here that for the Office of Rural Health Policy Research Centers, the administration is supporting $3.1 million, exactly what you are asking for, and in all other categories they have zeroed it out. What are we going to do about that?

Mr. **Richards.** We would like your support. We think we need this in an effort to do the things that we are doing well.

Senator **Burdick.** I hope by this time you realize we have a tough job.

Mr. **Richards.** Yes, sir; we appreciate your interest and your dedication.

Senator **Burdick.** Thank you.

Mr. **Richards.** Thank you.

STATEMENT OF CHARLES O. CRANFORD, D.D.S., UNIVERSITY OF ARKANSAS FOR MEDICAL SCIENCES, ON BEHALF OF AREA HEALTH EDUCATION CENTERS PROGRAM

ACCOMPANIED BY:

DR. LAMONT NOTTINGHAM, WEST VIRGINIA UNIVERSITY MEDICAL CENTER, CHARLESTON DIVISION

JEFFREY A. JOHNSON, EASTERN VIRGINIA MEDICAL SCHOOL

Senator **Burdick.** Charles O. Cranford, D.D.S., University of Arkansas Medical Sciences.

Arkansas is the home of the Razorbacks?

Dr. **Cranford.** Yes, sir; home of the Razorbacks.

Thank you, Senator Burdick. I am Dr. Charles Cranford, the executive director of the Arkansas Area Health Education Center Program, or AHEC's, as we call them. With me are Dr. Lamont Nottingham of West Virginia University Medical Center, Charleston Division, and Mr. Jeffrey A. Johnson of the Eastern Virginia Medical School. Both of these gentlemen direct AHEC projects in their States.

We are here today on behalf of 27 AHEC projects in 26 States. We appreciate the past support that we have received from this subcommittee.

We urge the full appropriation of $20 million authorized for the fiscal year that begins on October 1, 1989. We also support an additional appropriation of $8 million for the new health education training centers within the AHEC authority.

The problem addressed by AHEC is the maldistribution of physicians, nurses, and other health practitioners in rural and inner city areas. I am happy to report that we are making important progress. However, much remains to be done. Many rural inner city areas around the United States still do not have enough nurses, physicians, and other health professionals. The simple truth is that these health professionals do not set up practice in rural or any inner city areas unless they receive a lot of special attention. The AHEC program provides that attention.

The AHEC program has evolved into an effective partnership. For example, in my State of Arkansas, over 500 of our State's private physicians regularly teach through our AHEC program. The AHEC programs enable students and medical residents at Health Science Schools to take a portion of their clinical training at rural community hospitals. Students receive an exposure to practicing physicians in a community setting.

The hope is that health professionals will decide to practice in rural and inner city areas. In Arkansas, 82 percent of the family practice physicians trained in AHEC's have remained in the State; 37 percent of those have located in towns of fewer than 10,000 persons. Moreover, this percentage is increasing and has been 50 percent during the last 3 years.

Mr. Chairman, the AHEC program has proven to have been a wise investment. Federal spending has led to the establishment of AHEC's for 32 States, and it has spurred hundreds of millions of dollars for AHEC programs in response. This year, for example, the State of Arkansas spends more than $10 for every $1 of Federal support received for AHEC from the Federal program.

PREPARED STATEMENT

We hope that in the fiscal year 1990 budget Congress will maintain its commitment to a program aimed at ending the maldistribution of physicians and health practitioners in rural and inner city areas. Thank you again for the opportunity to appear.

[The statement follows:]

STATEMENT OF CHARLES O. CRANFORD

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE, I AM DR. CHARLES CRANFORD, AND I AM THE EXECUTIVE DIRECTOR OF THE ARKANSAS AREA HEALTH EDUCATION CENTERS PROGRAM, OR AHEC, AS WE CALL IT. WITH ME ARE DR. LAMONT NOTTINGHAM OF THE WEST VIRGINIA UNIVERSITY MEDICAL CENTER - CHARLESTON DIVISION AND MR. JEFFREY A. JOHNSON OF THE EASTERN VIRGINIA MEDICAL SCHOOL. BOTH SCHOOLS HAVE AHEC PROJECTS.

WE ARE HERE TODAY ON BEHALF OF 27 AHEC PROJECTS IN 26 STATES THAT ARE RECEIVING FEDERAL AHEC FUNDING THROUGH THE HEALTH RESOURCES AND SERVICES ADMINISTRATION.

AS WE HAVE INDICATED IN PREVIOUS APPEARANCES, WE APPRECIATE THE SUPPORT THAT WE HAVE RECEIVED THROUGH THE YEARS FROM YOU AND FROM THIS SUBCOMMITTEE. WE BELIEVE IT IS ESSENTIAL THAT THE NATIONAL AHEC PROGRAM CONTINUE. WE URGE THE FULL APPROPRIATION OF $20 MILLION AUTHORIZED FOR THE FISCAL YEAR THAT BEGINS OCTOBER 1, 1989. WE ALSO SUPPORT AN ADDITIONAL APPROPRIATION OF $8 MILLION FOR THE NEW HEALTH EDUCATION AND TRAINING CENTERS WITHIN THE AHEC AUTHORITY.

THROUGHOUT THE UNITED STATES WE CONTINUE TO ATTACK THE PROBLEM THAT LED TO THE ESTABLISHMENT OF THE NATIONAL AHEC PROGRAM - THAT PROBLEM BEING THE MALDISTRIBUTION OF PHYSICIANS AND OTHER HEALTH PRACTITIONERS IN RURAL AND INNER CITY AREAS. I AM HAPPY TO REPORT, MR. CHAIRMAN, THAT WE ARE MAKING IMPORTANT PROGRESS.

IN MY STATE OF ARKANSAS, FOR EXAMPLE, 50 OF OUR 75 COUNTIES HAVE RECEIVED FAMILY PRACTICE PHYSICIANS TRAINED IN THE AHEC. IN THE STATE OF NORTH CAROLINA, IN THE DECADE SINCE ESTABLISHING THE AHEC

PROGRAM, 89 PERCENT OF THE STATE'S COUNTIES HAVE EXPERIENCED IMPROVEMENTS IN THEIR PHYSICIAN TO POPULATION RATIOS, COMPARED TO ONLY 41 PERCENT IN THE DECADE BEFORE THE AHEC PROGRAM.

ALTHOUGH MANY AMERICANS NOW ENJOY A STANDARD OF HEALTH CARE THAT WOULD HAVE SEEMED UNIMAGINABLE TWO DECADES AGO, MUCH REMAINS TO BE DONE. MANY RURAL AND INNER CITY AREAS AROUND THE UNITED STATES STILL DO NOT HAVE ENOUGH PHYSICIANS, NURSES AND OTHER HEALTH PROFESSIONALS. PARTICULARLY DISTRESSING IS THE FACT THAT THIS PROBLEM PERSISTS AT A TIME WHEN WE ARE HEARING A LOT OF TALK ABOUT A POTENTIAL OVERSUPPLY OF PHYSICIANS IN GENERAL. THE SIMPLE TRUTH IS THAT YOUNG PHYSICIANS DO NOT TEND TO SET UP PRACTICE IN RURAL OR INNER CITY AREAS UNLESS THEY RECEIVE A LOT OF SPECIAL ATTENTION. AHEC PROVIDES THAT ATTENTION.

THE MALDISTRIBUTION OF HEALTH PROFESSIONALS IS A TERRIBLY DIFFICULT PROBLEM, MR. CHAIRMAN. THAT WAS SOMETHING THAT WE IN THE HEALTH EDUCATION COMMUNITY RECOGNIZED AT THE TIME THAT THE AHEC CONCEPT WAS BEING DEVELOPED. THE CONGRESS RECOGNIZED IT, TOO, AND PASSED LEGISLATION THAT PROVIDED FEDERAL FUNDS FOR THE NATIONAL AHEC PROGRAM. EVERYONE INVOLVED KNEW WE WERE TALKING ABOUT A TREMENDOUS EFFORT THAT WOULD NEED TO BE MEASURED IN TERMS OF DECADES, NOT YEARS.

THE WEST VIRGINIA AHEC PROGRAM HAS BEEN AN INTEGRAL COMPONENT OF THESE NATIONAL AHEC EFFORTS SINCE ITS INCEPTION IN 1972. THE AHEC IN WEST VIRGINIA HAS CONTRIBUTED SIGNIFICANTLY TO THE ENHANCEMENT OF MEDICAL EDUCATION IN THE SOUTHERN PART OF THE STATE. TODAY, ONE-THIRD OF ALL MEDICAL STUDENTS FROM WEST VIRGINIA UNIVERSITY SPEND TWO YEARS OF THEIR UNDERGRADUATE MEDICAL EDUCATION IN THE CHARLESTON AREA, 166 MILES FROM THE MAIN CAMPUS IN MORGANTOWN. A STATEWIDE AHEC

PROGRAM IS EVOLVING TO ADDRESS THE HIGH PERCENTAGE OF MEDICALLY UNDERSERVED COUNTIES IN WEST VIRGINIA, LOCATED IN THE HEART OF APPALACHIA.

THE AHEC PROGRAM HAS EVOLVED INTO AN EFFECTIVE PARTNERSHIP INVOLVING THE FEDERAL GOVERNMENT, STATE GOVERNMENTS, LOCAL GOVERNMENTS, HEALTH SCIENCE SCHOOLS, COMMUNITY HOSPITALS AND HEALTH PRACTITIONERS. THE PARTNERSHIP INVOLVES THE OTHER PRIMARY CARE INITIATIVES OF THE FEDERAL GOVERNMENT, AS WELL. THAT KIND OF COOPERATION SEEMS TO HAPPEN ALL TOO RARELY IN OUR SOCIETY, AND WE WHO ARE ASSOCIATED WITH AHEC FEEL MOST FORTUNATE. WE HAVE ALL TYPES OF PEOPLE FROM THE PUBLIC AND PRIVATE SECTORS WORKING TOGETHER IN PURSUIT OF A COMMON PUBLIC POLICY OBJECTIVE. FOR EXAMPLE, IN ARKANSAS, OVER 500 OF OUR STATE'S PRIVATE PHYSICIANS REGULARLY TEACH THROUGH OUR AHEC PROGRAM.

THE AHEC PROGRAMS ENABLE STUDENTS AND MEDICAL RESIDENTS AT HEALTH SCIENCE SCHOOLS TO TAKE A PORTION OF THEIR CLINICAL TRAINING AT COMMUNITY HOSPITALS AND HEALTH CENTERS--AN ARRANGEMENT THAT ENDS UP BENEFITING EVERYONE. THE STUDENTS AND THE RESIDENTS RECEIVE AN EXPOSURE TO PRACTICING PHYSICIANS IN A COMMUNITY SETTING--SOMETHING THEY MIGHT NOT HAVE HAD OTHERWISE. THE LOCAL AGENCIES GET THE SERVICES OF HIGHLY QUALIFIED HEALTH PERSONNEL AND THE PEOPLE OF THE COMMUNITY HAVE ACCESS TO BETTER HEALTH CARE.

THE HOPE OF COURSE, IS THAT SOME OF THE YOUNG HEALTH PROFESSIONALS WHO PARTICIPATE IN THIS COMMUNITY-BASED PROGRAM WILL DECIDE AFTER COMPLETING THEIR EDUCATION TO PRACTICE IN RURAL OR INNER CITY AREAS--THE AREAS WHERE HELP IS DESPERATELY NEEDED. IN ARKANSAS, 82 PERCENT OF THE FAMILY PRACTICE PHYSICIANS TRAINED IN AHECS HAVE REMAINED IN THE STATE, AND 37 PERCENT OF THOSE HAVE LOCATED IN TOWNS OF FEWER

THAN 10,000 PERSONS. MOREOVER, THIS PERCENTAGE IS INCREASING AND HAS BEEN 50 PERCENT DURING THE LAST THREE YEARS.

THE AHEC PROGRAMS ALSO WORK WITH HEALTH SCIENCE SCHOOLS TO OFFER CONTINUING EDUCATION AND TECHNICAL ASSISTANCE TO PRACTICING HEALTH PROFESSIONALS THROUGHOUT THE STATE. THIS SERVICE NOT ONLY HELPS COMMUNITY-BASED PROFESSIONALS FEEL LESS ISOLATED BUT ALSO ASSURES THEM THAT THEY CAN KEEP UP TO DATE EVEN IF THEY PRACTICE FAR FROM THE MAJOR MEDICAL CENTERS.

I AM HAPPY TO ALSO REPORT THAT AHEC'S AROUND THE NATION HAVE BEEN SUCCESSFUL IN ADAPTING PROGRAMMING TO MEET CHANGING COMMUNITY NEEDS. MAJOR EFFORTS HAVE BEEN UNDERTAKEN TO DEVELOP INTERDISCIPLINARY EDUCATIONAL PROGRAMS IN COMMUNITY SETTINGS IN THE AREAS OF AGING, HEALTH PROMOTION AND DISEASE PREVENTION, AIDS, HEALTH SERVICES MANAGEMENT, COST CONTAINMENT, MENTAL HEALTH, AND QUALITY ASSURANCE.

MR. CHAIRMAN, THE NATIONAL AHEC PROGRAM HAS PROVEN TO HAVE BEEN A WISE INVESTMENT FOR THE FEDERAL GOVERNMENT. SINCE 1972, FEDERAL FUNDING FOR AHECS NATIONWIDE HAS TOTALED ABOUT THE SAME AMOUNT THAT THE U.S. OBLIGATES FOR THE HEALTH CARE FINANCING ADMINISTRATION EVERY TWO TO THREE DAYS. THAT MODEST AMOUNT OF FEDERAL SPENDING HAD LED TO THE ESTABLISHMENT OF AHECS FOR 32 STATES, 26 OF WHICH ARE STILL RECEIVING FEDERAL FUNDS. AND IT HAS SPURRED STATE AND LOCAL GOVERNMENTS INTO SPENDING HUNDREDS OF MILLIONS OF DOLLARS FOR AHEC PROGRAMS IN RESPONSE TO THE FEDERAL CATALYST. THIS YEAR, FOR EXAMPLE, THE STATE OF ARKANSAS SPENDS MORE THAN $10 FOR EVERY DOLLAR OF FEDERAL SUPPORT RECEIVED FOR AHEC.

THE NATIONAL AHEC PROGRAM DEMONSTRATES OUR GOVERNMENT WORKING AT ITS BEST. WE INVITE THE SUBCOMMITTEE TO REVIEW THE STRONG ENDORSEMENTS OF THE AHEC PROGRAM CONTAINED IN THE FOLLOWING STUDIES:

1. THE 1978 REPORT OF THE GENERAL ACCOUNTING OFFICE;
2. THE 1978 REPORT OF THE HOUSE APPROPRIATIONS COMMITTEE;
3. THE 1976 AND 1979 REPORTS OF THE CARNEGIE COUNCIL;
4. THE 1980 REPORT TO THE CONGRESS BY THE SECRETARY OF H.E.W. AND
5. THE 1980 GMENAC REPORT.

WE IN AHEC HOPE THAT, IN THE FISCAL YEAR 1990 BUDGET, THE CONGRESS WILL MAINTAIN ITS COMMITMENT TO A PROGRAM AIMED AT ENDING THE MALDISTRIBUTION OF PHYSICIANS AND HEALTH PRACTITIONERS IN RURAL AND INNER-CITY AREAS. THIS COMMITMENT ALLOWS FOR FUNDING OF STATEWIDE AHEC'S, REGIONAL AHEC'S, AHEC SPECIAL INITIATIVES, INFANT MORTALITY, AND HIGH IMPACT AREAS. THE UNITED STATES, MR. CHAIRMAN, CANNOT AFFORD TO BE WITHOUT THIS PROGRAM.

THANK YOU AGAIN FOR THE OPPORTUNITY TO APPEAR HERE TODAY. WE IN THE AHEC PROGRAM LOOK FORWARD TO CONTINUING TO WORK WITH THE CONGRESS IN THE INTEREST OF ENSURING ACCESS TO PROPER HEALTH CARE FOR ALL AMERICANS.

Senator **Burdick**. That, of course, has been one of the problems we have had out in the rural areas; that many, I would say, of our aspiring doctors have gone to the bright lights.

Dr. **Cranford**. Yes, sir.

Senator **Burdick**. This program, in your opinion, has been holding some of them in the States?

Dr. **Cranford**. Yes; we are a singular program in some States attempting to get health practitioners in rural areas.

Senator **Burdick**. Again, we find the administration recommends nothing. You want $20 million.

Dr. **Cranford**. That is right, and we will appeal to our representatives who know that we have a good program and is doing a good job in our States to help us.

Senator **Burdick**. We will do our best.

Dr. **Cranford**. Thank you, sir.

STATEMENT OF MARSHALL SINBACK, AMERICAN ACADEMY OF PHYSICIAN ASSISTANTS

Senator **Burdick**. Marshall Sinback, American Academy of Physician Assistants.

Welcome to the committee.

Mr. **Sinback**. Thank you, Senator Burdick.

On behalf of the American Academy of Physician Assistants and the 20,000 physician assistants we represent, I want to thank you for the opportunity to address you concerning the fiscal year 1990 Labor, Health and Human Services appropriations bill. As you noted, I am Marshall Sinback. I am a physician assistant and president of the academy. I am also the administrative officer for the surgical service at the Atlanta VA Medical Center.

Senator, as you may recall from our testimony last year, the demand for physician assistant services is at an all-time high. While this is certainly welcome news to individual physician assistants, it is having a decisively negative impact on access to health care for millions of Americans.

Hospitals, nursing homes, and private practices are expressing an unprecedented interest in demand for utilizing physician assistants for the care of their patients. More importantly, projections are that the demand is going to remain strong for the foreseeable future. While the demand for physician assistants remains strong, the supply of physician assistants unfortunately has not kept pace.

As a result, many communities and practices that have relied on physician assistants as a means of primary care provision are now finding it extremely difficult, if not impossible, to find a physician assistant when a vacancy does occur.

Recent surveys of hospitals in Maine have revealed, for instance, that the vacancy rate for physician assistants is the highest of any health professional in that State in excess of 20 percent. The problem is particularly acute in the rural hospitals, and the same is true in New York where recent restrictions on the number of hours that residents can work has identified other providers such as physician assistants and nurse practitioners as an alternative. However, the availability in meeting that demand is of great question at the present time.

Mr. Chairman, New York and Maine are really not unique. We are receiving similar reports from all regions of the country. I mention all of this as a prelude to the purpose of our testimony today, which is to seek the full funding, $5.2 million, for physician assistant education.

As you know, Mr. Chairman, Congress reauthorized Federal funds for physician assistant education and provided a modest increase of 13 percent in the authorization bill. The rationale for this increase was the recognition that Federal support for physician assistant education has remained static for too long, and the shortage of physician assistants was having an undesirable effect on the cost and access to health care for millions of Americans.

By fully funding physician assistant program grants to the fiscal year 1990 authorized level, Congress will make enough money available to assist in the startup of very badly needed new physician assistant programs which have been specifically geared to produce physician assistants who will work in targeted medically underserved communities.

This past year, for instance, at the George Washington University here in the District, a Federal program grant was obtained by the program to start the first physician assistant volunteer community service program. Under this program, physician assistant students are required to volunteer a minimum of 6 to 8 hours per month over an 18-month period to a local volunteer agency.

In the District here, physician assistants have been working with such diverse groups as the House of Ruth, which is a homeless shelter for women, the Washington Home and Hospice caring for AIDS patients, and the Washington Free Clinic, to name just a few.

It is hoped by exposing these young professionals to the needs of the underserved communities during their physician assistant education we will increase the likelihood that they will seek out future opportunities in these communities upon graduation.

Physician assistant programs have already led the way for nursing and medicine in the areas of increased minority representation in the health care fields and the percentages of practitioners working in rural medically underserved communities. We hope this new program will be just as successful.

Senator, at a time when Congress is debating budget figures that are in the billions, it is very easy sometimes to lose sight of the tiny programs that cost only a few million, but to do so is unfortunate. While physician assistant program grants may not be one of the larger health profession programs, it is certainly one of the most successful. We trust that you will not overlook the success but instead reward it by increasing the grants for the physician assistant education so that we can graduate enough physician assistants to meet the current growing demand.

PREPARED STATEMENT

Your past support for physician assistant education has been greatly appreciated, and we look forward to your continued support and in working with you and your staff for the future.

That concludes my testimony, and I would be happy to answer any questions that you might have.

[The statement follows:]

STATEMENT OF MARSHALL SINBACK

MR. CHAIRMAN, ON BEHALF OF THE AMERICAN ACADEMY OF PHYSICIAN ASSISTANTS AND THE 20,000 PHYSICIAN ASSISTANTS WE REPRESENT, I WANT TO THANK YOU FOR THIS OPPORTUNITY TO PRESENT OUR VIEWS ON THE FY 1990 LABOR - HEALTH AND HUMAN SERVICES APPROPRIATIONS BILL.

AS YOU HAVE NOTED, I AM MARSHALL SINBACK, PA-C, PRESIDENT OF THE ACADEMY. I AM ALSO THE ADMINISTRATIVE OFFICER FOR THE DEPARTMENT OF SURGERY AT THE VA MEDICAL CENTER IN ATLANTA, GEORGIA.

AS THE PHYSICIAN ASSISTANT PROFESSION PREPARES TO CELEBRATE ITS 22nd BIRTHDAY, I AM PLEASED TO SAY THAT THE FUTURE FOR PAs HAS NEVER BEEN BRIGHTER. LATER THIS MONTH, THE PROFESSION WILL BE HOLDING ITS 17th ANNUAL CONFERENCE HERE IN WASHINGTON, DC AND WE ARE ESTIMATING THAT THERE WILL BE CLOSE TO 4,000 PAs IN ATTENDANCE FOR ALL OR PART OF THIS CONVENTION.

AS YOU MAY RECALL FROM OUR TESTIMONY LAST YEAR, DEMAND FOR THE SERVICES OF PHYSICIAN ASSISTANTS IS AT AN ALL-TIME HIGH. WHILE THIS IS WELCOME NEWS TO THE INDIVIDUAL PA, IT IS HAVING A DECIDEDLY NEGATIVE IMPACT ON ACCESS TO HEALTH CARE FOR MILLIONS OF AMERICANS.

HOSPITALS, NURSING HOMES AND PRIVATE PRACTICES ARE EXPRESSING UNPRECEDENTED INTEREST IN UTILIZING PAs IN THE CARE OF THEIR PATIENTS. MORE IMPORTANTLY, PROJECTIONS ARE THAT DEMAND WILL REMAIN STRONG FOR THE FORESEEABLE FUTURE. WHILE THE DEMAND FOR PAs REMAINS STRONG, THE SUPPLY OF PAs HAS NOT KEPT PACE.

AS A RESULT, MANY COMMUNITIES AND PRACTICES THAT RELIED ON PHYSICIAN ASSISTANTS AS THEIR PRIMARY CARE PROVIDER, ARE NOW FINDING IT EXTREMELY DIFFICULT, IF NOT IMPOSSIBLE, TO FIND A PA WHEN A VACANCY OCCURS.

A RECENT SURVEY OF HOSPITALS IN MAINE, CONDUCTED BY ERNST AND WHINNEY, REVEALED THAT THE VACANCY RATE FOR PHYSICIAN ASSISTANTS IS THE HIGHEST OF ANY HEALTH PROFESSIONAL IN THE STATE - IN EXCESS OF 20%. THE PROBLEM IS PARTICULARLY ACUTE IN RURAL HOSPITALS. THE SAME IS TRUE IN NEW YORK WHERE THE DEMAND FOR PAs IS EXPECTED TO SKYROCKET WITH THE ADVENT OF NEW RESTRICTIONS ON THE HOURS RESIDENTS MAY WORK.

INDEED, A RECENT ARTICLE IN AMERICAN MEDICAL NEWS STATES THAT TEACHING HOSPITALS IN NEW YORK DOUBT THEY WILL BE ABLE TO FIND, "...MORE HIGHLY TRAINED PERSONNEL WHO ARE ALREADY IN SHORT SUPPLY, -- NURSES AND PHYSICIAN'S ASSISTANTS,"

MR. CHAIRMAN, NEW YORK AND MAINE ARE NOT UNIQUE. WE ARE RECEIVING SIMILAR REPORTS FROM ALL REGIONS OF THE COUNTRY.

I MENTION ALL OF THIS AS A PRELUDE TO THE REAL PURPOSE OF OUR TESTIMONY WHICH IS TO SEEK FULL FUNDING - $5.2 MILLION - FOR PHYSICIAN ASSISTANT EDUCATION.

AS YOU KNOW, MR. CHAIRMAN, LAST YEAR CONGRESS REAUTHORIZED FEDERAL FUNDS FOR PHYSICIAN ASSISTANT EDUCATION AND PROVIDED A MODEST INCREASE OF 13% IN THE AUTHORIZATION LEVEL.

THE RATIONALE FOR THIS INCREASE WAS A RECOGNITION THAT FEDERAL SUPPORT FOR PA EDUCATION HAD REMAINED STATIC FOR TOO LONG AND THE SHORTAGE OF PAs WAS HAVING AN UNDESIRABLE EFFECT ON THE COST OF AND ACCESS TO HEALTH CARE FOR MILLIONS OF AMERICANS.

BY FULLY FUNDING PA PROGRAM GRANTS TO THE FY '90 AUTHORIZED LEVEL, CONGRESS WILL MAKE ENOUGH MONEY AVAILABLE TO ASSIST IN THE START-UP OF SEVERAL NEW PA PROGRAMS THAT ARE PRESENTLY IN THE PIPELINE. THESE PROGRAMS ARE SPECIFICALLY GEARED TO PRODUCE PAs WHO WILL WORK IN TARGETED MEDICALLY UNDERSERVED COMMUNITIES.

IN ADDITION TO HELPING GRADUATE MORE PAs, FULL FUNDING WILL ALLOW FOR THE CONTINUATION OF MANY INNOVATIVE PROGRAMS ALREADY

BEING SUPPORTED BY FEDERAL GRANTS. I WOULD LIKE TO TELL YOU ABOUT ONE SUCH INITIATIVE HERE IN WASHINGTON, DC.

THIS PAST YEAR, THE GEORGE WASHINGTON UNIVERSITY PHYSICIAN ASSISTANT PROGRAM RECEIVED A FEDERAL GRANT TO START THE FIRST PA VOLUNTEER COMMUNITY SERVICE PROGRAM. UNDER THIS PROGRAM, THE PA STUDENTS ARE REQUIRED TO VOLUNTEER A MINIMUM OF 6 - 8 HOURS PER MONTH OVER AN 18 MONTH PERIOD TO A LOCAL VOLUNTEER AGENCY.

OUT OF THE 60 DIFFERENT LOCAL AGENCIES WHICH EXPRESSED INTEREST IN PARTICIPATING IN THIS INNOVATIVE PROGRAM, 20 WERE CHOSEN TO MAKE PRESENTATIONS TO THE STUDENTS. ALTHOUGH THE PROGRAM ONLY STARTED IN JANUARY, THE RESPONSE FROM BOTH STUDENTS AND ORGANIZATIONS HAS BEEN OVERWHELMING.

PA STUDENTS ARE WORKING WITH SUCH DIVERSE GROUPS AS THE HOUSE OF RUTH, A HOMELESS SHELTER FOR WOMEN, THE WASHINGTON HOME AND HOSPICE, CARING FOR AIDS PATIENTS, AND THE WASHINGTON FREE CLINIC, TO NAME JUST A FEW. PERHAPS THE SUCCESS OF THIS PROGRAM CAN BEST BE SUMMED UP BY THE COMMENTS OF SOME OF THE STUDENTS WHO WERE ASKED TO TALK ABOUT THEIR EXPERIENCES,

> "THE VOLUNTEER EXPERIENCE HAS HELPED TO BRING MY PA TRAINING INTO PERSPECTIVE. WE'RE EIGHT MONTHS INTO THE DIDACTIC (classroom) TRAINING AND SPEND LONG HOURS STUDYING. THIS VOLUNTEER EXPERIENCE HELPS US TO REMEMBER WHY WE ARE HERE."

or

> "IT HAS REALLY GIVEN ME AN APPRECIATION FOR DIFFERENT TYPES OF PEOPLE WHO ARE HOMELESS, PEOPLE I DON'T USUALLY DEAL WITH ON A ONE-TO-ONE BASIS EVERY DAY. WORKING AT A HOMELESS SHELTER HAS HELPED ME TO KNOW HOW THESE INDIVIDUALS PERCEIVE THINGS, WHAT THEY NEED, AND TO SEE THEM AS REAL PEOPLE."

IT IS HOPED THAT BY EXPOSING THESE YOUNG PROFESSIONALS TO THE NEEDS OF THE UNDERSERVED COMMUNITIES DURING THEIR PA EDUCATION, WE WILL INCREASE THE LIKELIHOOD THAT THEY WILL SEEK OUT FUTURE OPPORTUNITIES IN THESE COMMUNITIES UPON GRADUATION.

PA PROGRAMS, MR. CHAIRMAN, HAVE BEEN INNOVATORS IN THE EDUCATION OF HEALTH PROFESSIONALS. IF, AS IS SUSPECTED, THIS PROGRAM IS SUCCESSFUL AT INCREASING THE NUMBER OF PAs WORKING AND CARING

FOR MEDICALLY UNDERSERVED POPULATIONS, THEN THIS PROGRAM CAN BE ADAPTED FOR BOTH THE PHYSICIAN AND NURSING COMMUNITIES.

PA PROGRAMS HAVE ALREADY LED THE WAY FOR NURSING AND MEDICINE IN THE AREA OF INCREASED MINORITY REPRESENTATION IN THE HEALTH FIELD AND IN PERCENTAGES OF PRACTITIONERS WORKING IN RURAL MEDICALLY UNDERSERVED COMMUNITIES. WE HOPE THIS NEW PROGRAM IS JUST AS SUCCESSFUL.

AT A TIME WHEN WE SEE CONGRESS DEBATING BUDGET FIGURES IN THE BILLIONS, IT IS SOMETIMES EASY TO LOSE SIGHT OF THOSE "TINY" PROGRAMS THAT ONLY COST A FEW MILLION. BUT TO DO SO IS UNFORTUNATE. WHILE PA PROGRAM GRANTS MAY NOT BE ONE OF THE LARGER HEALTH PROFESSIONS PROGRAMS, IT IS CERTAINLY ONE OF THE MOST SUCCESSFUL.

WE TRUST THAT YOU WILL NOT OVERLOOK THIS SUCCESS BUT INSTEAD, REWARD IT BY INCREASING THE GRANTS FOR PA EDUCATION SO THAT WE CAN GRADUATE ENOUGH PAs TO MEET THE GROWING DEMAND.

YOUR PAST SUPPORT FOR PA EDUCATION HAS BEEN APPRECIATED AND WE LOOK FORWARD TO WORKING WITH YOU AND YOUR STAFF IN THE FUTURE.

Senator BURDICK. Here again, the administration does not agree with you.

Mr. SINBACK. That is quite true.

Senator BURDICK. Fiscal year 1989 is $4.5 million, and you are asking for $5.2 million?

Mr. SINBACK. Full authorization.

Senator BURDICK. Mr. Bush wants nothing. How are we going to resolve that?

Mr. SINBACK. We are going to try to work real hard hopefully and do the best we can.

Senator BURDICK. Do you support funding for interdisciplinary traineeships for rural health? Would a physician assistants program participate in this kind of an interdisciplinary program?

Mr. SINBACK. I believe they would.

Thank you very much.

STATEMENT OF SCOTT R. SWIRLING, EXECUTIVE DIRECTOR, NATIONAL FAMILY PLANNING AND REPRODUCTIVE HEALTH ASSOCIATION

Senator COCHRAN [presiding]. Our next witness will be Scott Swirling, National Family Planning and Reproductive Health Association.

Mr. SWIRLING. Thank you, Senator. I am Scott Swirling, executive director of the National Family Planning and Reproductive Health Association, NFPRHA. I thank you for the opportunity to address the issue of continued funding for title 10 of the Public Health Service Act, the Population Research and Voluntary Family Planning Programs.

NFPRHA is a nonprofit membership organization established to improve and expand the delivery of voluntary family planning and reproductive health services throughout the United States. As the only national organization representing the entire family planning community, NFPRHA's members comprise almost grantees funded under the national title 10 family planning program.

NFPRHA represents 74 of the 89 title 10 grantees across the United States who in fiscal year 1989 received nearly 90 percent of the title 10 family planning service dollars. Among those NFPRHA represents are hospitals, State and local health departments including the State of North Dakota Health Department, affiliates of the Planned Parenthood Federation of America, independent nonprofit family planning agencies, doctors, nurses, researchers, and consumers of reproductive health services.

NFPRHA has five fiscal year 1990 appropriations recommendations for this committee and the Congress.

One, reauthorize the title 10 statute as a categorical grant program through passage of the Kennedy bill, S. 110, and reject the Bush adminstration's proposal to replace title 10 with a block grant State administered family planning program. You, Senator, are a cosponsor of that bill, and I appreciate your cosponsorship of S. 110.

Second, we would like to see appropriated $177,515,000 for programs under title 10 for service program grants and contracts, training grants and contracts, and expanded community based information education programs targeted especially for teenagers and parents. These figures equal the fiscal year 1990 authorization levels provided under S. 110 now pending before the Labor and Human Resources Committee.

The authorization of the title 10 statute expired on September 30, 1985. For the last 4 fiscal years, title 10 appropriation has been carried on a series of continuing resolutions and the Fiscal Year 1989 HHS Appropriations Act. The result has been a reduction of the funds appropriated for title 10 and an inability of the program to institute needed statutory reforms.

In the last 8 years, title 10's appropriation has gone from $162 million to $135.1 million. Inflationary increases alone would have brought the current level of funding to an excess of $237 million by this year.

Third, we would like to see appropriated funds required for the administration of the title 10 program by the Office of Population Affairs in addition to and in a separate line item from the appropriation for the family planning program activities and clearly delineate the exact amount of the appropriation for administrative expenses in committee and conference reports.

Fourth, we would like to see this committee repudiate the inappropriate administration of the title 10 family planning program by the Office of Population Affairs and resist all efforts to compromise the quality, confidentiality, or scope of title 10 services.

Finally, we would like this committee and the Congress to appropriate funding for the Center for Population Research within the National Institute of Child Health and Human Development at least at last year's appropriation level and, in addition, appropriate an additional $10 million for the specific development and evaluation of new or improved contraceptives as per the provisions of S. 110.

Women and men in the United States have fewer contraceptive options available to them than are available to individuals in Europe and even in many less developed countries. Current contraceptive methods are inadequate. Title 10 agencies serving the most vulnerable in our population need to be able to provide better, more diverse contraceptive options to their patients.

In summary, despite serious administration attempts over the past 8 years to undermine, the successes of the national title 10 family planning program cannot be ignored. They speak forcefully for the reauthorization of title 10 and for NFPRHA's request that this subcommittee and Congress approve an appropriation for title 10 of $177,515,000 for fiscal year 1990.

PREPARED STATEMENT

Adequate funding of family planning and contraceptive research programs will send a strong message that Congress and this committee hold reproductive health care as a high priority even in these times of fiscal constraint.

Thank you very much, Mr. Harkin.

[The statement follows:]

STATEMENT OF SCOTT R. SWIRLING

RECOMMENDATIONS OF THE NATIONAL FAMILY PLANNING AND REPRODUCTIVE HEALTH ASSOCIATION FOR FISCAL YEAR 1990 APPROPRIATIONS FOR THE TITLE X (PHS ACT) FAMILY PLANNING PROGRAM

(1) Reauthorize the Title X statute as a categorical grant program for three years through passage of the Kennedy bill -- S. 110 -- and reject the Bush Administration's proposal to replace Title X with a block grant "state administered family planning program."

(2) Appropriate $177,515,000 for programs under Title X: $163,000,000 for service program grants and contracts, $4,515,000 for training grants and contracts, and $10,000,000 for expanded community-based information and education programs, targeted especially for teenagers and parents, to help prevent and lower the incidence of unintended pregnancy and sexually transmitted diseases. These figures equal the fiscal year 1990 authorization levels provided under S. 110 now pending before the Labor and Human Resources Committee.

(3) Appropriate funds required for the administration of the Title X program by the Office of Population Affairs in addition to, and in a separate line item from, the appropriation for family planning program activities, and clearly delineate the exact amount of the appropriation for administrative expenses in committee and conference reports.

(4) Repudiate the inappropriate administration of the Title X family planning program by the Office of Population Affairs, and resist all efforts to compromise the quality, confidentiality, or scope of Title X services.

(5) Appropriate funding for the Center for Population Research within the National Institute of Child Health and Human Development at least at last year's appropriation level of nearly $129 million. In addition, appropriate an additional $10 million for the specific development and evaluation of new or improved contraceptives as per the provisions of S. 110.

Mr. Chairman and Members of the Subcommittee:

I am Scott R. Swirling, Executive Director of the National Family Planning and Reproductive Health Association (NFPRHA). I thank you for the opportunity to address the issue of continued funding for Title X of the Public Health Service Act, "Population Research and Voluntary Family Planning Programs."

The National Family Planning and Reproductive Health Association (NFPRHA) is a non-profit membership organization headquartered in Washington, D.C., established to improve and expand the delivery of voluntary family planning and reproductive health services throughout the United States. As the only national organization representing the entire family planning community, NFPRHA's members comprise almost all grantees funded under the national Title X family planning program. NFPRHA represents 74 of the 89 Title X grantees across the United States who, in fiscal year 1989, received nearly 90 percent of the Title X family planning service dollars. Among those NFPRHA represents are hospitals; state and local health departments; affiliates of the Planned

Parenthood Federation of America; independent non-profit family planning agencies; individual doctors, nurses, and researchers; and consumers of reproductive health care services. NFPRHA is committed to establishing and maintaining reproductive health care as a high priority preventive health care service in this country.

TITLE X -- A NECESSARY PUBLIC HEALTH PROGRAM

In a message to the Congress in July 1970, President Richard M. Nixon stated, "It is my view that no American woman should be denied access to family planning assistance because of her economic condition. I believe, therefore, that we should establish as a national goal the provision of adequate family planning services within the next five years to all those who want them but cannot afford them. This we have the capacity to do."

The Family Planning Services and Population Research Act (P.L. 91-572) subsequently was signed into law by President Nixon in December 1970. During the eighteen years since then, the national family planning program has been an integral component of the panoply of programs designed to improve public health in the United States.

This significant commitment to public funding for family planning services was an outgrowth of several events in the 1960s. The emergence of the oral contraceptive (the "birth control pill") and the intrauterine device (IUD) made relatively safe, effective and convenient contraception a reality for American couples. Research studies documented that repeated, closely spaced childbearing and childbearing very early or very late in a woman's reproductive years often had adverse health, social and economic consequences both for mothers and for their children. Other studies showed that most low-income women and men in the United States did not want more children than did more affluent families; rather, since they lacked the same level of access to contraceptive services, they were less successful in having the smaller families they desired. And finally, the U.S. Supreme Court recognized in 1965 the right of couples to practice contraception, and in 1972 extended that right to single individuals as well.

Title X is primarily a health services program that serves the poor and medically indigent. Through a network of over 4,000 clinics, family planning agencies serve as the entry point for millions of low-income women and adolescents into the nation's health care system. For many, it is the only source of health care readily available.

While the major purpose of Title X is to increase access to contraceptive services in an effort to reduce unintended pregnancy, it serves a variety of personal as well as social purposes, among them the upgrading of general reproductive health, the prevention or alleviation of poverty and government dependency, and improving the health and economic well-being of individual women, their children, and their families.

The Title X network is incredibly diverse, with providers of varied types offering family planning services with Title X funds. State and local health departments constitute the single largest group of providers, serving 40 percent of the Title X clients. Affiliates of the Planned Parenthood Federation of America serve 27 percent of the clients; hospitals, 13 percent; and a variety of other agencices such as health maintenance organizations, community health centers, and independent clinics serve the remaining 20 percent.

This network, established and operated under the Title X program, provides the infrastructure for the organized delivery of publicly-funded family planning services. While Title X is the single largest source of public support dedicated for family planning -- providing nearly one-third of the total public family planning funds -- it is augmented by: the Maternal and Child Health Block Grant (Title V of the Social Security Act); Medicaid (Title XIX of the Social Security Act); the Social Services Block Grant (Title XX of the Social Security Act); state and local funding; patient fees; other third party reimbursements; and private philanthropy.

The average Title X client is young, female, and has a low or marginal income. Sixty-nine percent of the clients are white, and eighty percent have incomes below 150 percent of the federal poverty level.

Typical Title X programs offer clinical health services (eg. physical examinations, contraceptive information and services, Pap smears, sexually transmitted disease screening and treatment, cancer screening, hemoglobin tests, urinalysis, pregnancy testing and diagnosis, basic gynecologic care); counseling services (for nutrition, infertility, parent/teen communication, maternal and child health, problem pregnancies, related medical problems); services for men (counseling, education, condoms); special teen clinics; adolescent health education; and community education programs.

Title X-funded agencies must ensure that individuals have a choice among all the different contraceptive methods, including natural family planning. Coercion to use a particular method -- or any method at all -- is strictly prohibited, and use of the clinic services themselves is entirely voluntary and confidential.

The need for the Title X program is clear and considerable. Although 3.5 million low-income women and 1.5 million adolescents receive services yearly from Title X clinics, 56 percent of the over 9.5 million low-income women and 69 percent of the five million sexually-active teenagers in need of subsidized family planning services still cannot obtain medically supervised reproductive health care.

Hundreds of thousands of unintended pregnancies, many among teenagers, are averted each year as a direct result of services provided by clinics receiving Title X funds.

Even with Title X, over fifty percent of the six million pregnancies yearly in this country are unintended; 1.1 million of those pregnancies are to teenagers. Eighty percent of all teenage pregnancies are unintended. Over 1.5 million abortions occur each year, more than 400,000 to teenagers.

Pregnancies avoided by the utilization of Title X family planning services limit the numbers of abortions and unintended births that occur each year in the United States.

Former Department of Health and Human Services Secretary Otis R. Bowen has noted, "Between their 13th and 19th birthdays, more than one quarter of all teenage girls will be pregnant at least once. Pregnancy among unmarried teens is a problem for both the girls having babies and the boys who father them. And it is a problem we all must face...not just the government, but all of us."

That problem is not simply whether a pregnant teenager chooses to give birth or to have an abortion. As the Center for Population Options documented in its 1986 study of the public costs of teenage childbearing, "The more than one million teenage pregnancies that occur each year are a serious problem for all of society. Not only is teenage childbearing a threat to the health and welfare of the mother and child, but adolescent pregnancy contributes to such societal problems as poverty, unemployment, family disintegration, juvenile crime, school dropouts and child abuse."

In addition, in 1985 the National Academy of Sciences' Institute of Medicine reported on the twin problems of low birthweight and infant mortality in the U.S. The study specifically found that access by low-income women and unmarried teenagers to Title X family planning services can significantly reduce the incidence of these tragic events.

Thus, the federal dollars invested in Title X to prevent pregnancy more than pay for themselves in savings in public health care and social service costs.

Unfortunately, despite the Presidential call for total access to family planning services by 1975, federal, state, and local financial support for family planning has never reached a level commensurate with need. Since the early 1970's, the number of medically indigent family planning clients has grown more than 60 percent, yet federal funding for family planning has not increased in real dollars since 1973.

The strong support of this subcommittee and the Congress for the Title X program will go a long way to ensuring that low-income women and sexually active teenagers will not have to go without the high quality, comprehensive family planning and reproductive health care services they so desperately desire and need to prevent unintended pregnancies and the severe consequences associated with such pregnancies.

FISCAL YEAR 1990 APPROPRIATIONS RECOMMENDATIONS

(1) Reauthorize the Title X statute as a categorical grant program for three years through passage of the Kennedy bill -- S. 110 -- and reject the Bush Administration's proposal to replace Title X with a block grant "state administered family planning program."

(2) Appropriate $177,515,000 for programs under Title X: $163,000,000 for service program grants and contracts, $4,515,000 for training grants and contracts, and $10,000,000 for expanded community-based information and education programs, targeted especially for teenagers and parents, to help prevent and lower the incidence of unintended pregnancy and sexually transmitted diseases. These figures equal the fiscal year 1990 authorization levels provided under S. 110 now pending before the Labor and Human Resources Committee.

The authorization of the Title X statute expired on September 30, 1985. For the last four fiscal years, the Title X appropriation has been carried on a series of Continuing Resolutions and the FY 1989 DHHS appropriations act. The result has been a reduction in the funds appropriated for Title X and an inability of the program to institute needed statutory reforms.

In the last eight years, Title X's appropriation has gone from $162 million in FY 1981 to $135.1 million in FY 1989. Inflationary increases alone should have brought the current level of Title X funding to in excess of $237 million by this year.

According to DHHS figures, the funding reductions directly attributable to the lack of a reauthorized Title X statute forced the closing of almost 1,000 family planning clinics and the curtailment of many services. Operating hours have been reduced, staff have been cut, and indigent patients have been asked to contribute more to the cost of services. The irony of this is, of course, that reducing a program as effective and cost-efficient as Title X results only in far greater social and financial costs down the line.

An overwhelming majority of Americans (more than 90 percent) from all racial, socio-economic and religious groups, support the provision of publicly-supported family planning services. Over 80 national organizations representing almost every segment of American life, actively support Title X. Among the reasons for such widespread support are that all persons should be able to freely determine the number and spacing of their children, that the timing and spacing of births has a direct impact upon the wellbeing of mothers and children, and that the availability of family planning services can be instrumental in preventing or alleviating poverty.

In addition, the Congress has demonstrated broad bipartisan support for Title X despite its inability to pass a reauthorization bill. Congress has repeatedly refused to accept the current administration's proposal that Title X be repealed and that family planning funds be rolled into a discretionary block grant to the states. This consistent reaffirmation by Congress of the need to maintain Title X as a categorical grant program has ensured national standards of care and service provision and is symbolic of the widespread public support the national family planning program enjoys.

(3) Appropriate funds required for the administration of the Title X program by the Office of Population Affairs in addition to, and in a separate line item from, the appropriation for family planning program activities, and clearly delineate the exact amount of the appropriation for administrative expenses in committee and conference reports.

From its first funding in FY 1971 through FY 1989, funding for Title X is contained within the account for the Health Resources and Services Administration (HRSA) and its predecessors. From FY 1971 through FY 1987, the appropriations committee reports listed only the funds for program grants and contracts under the "Family Planning" line item; all program management/program support funds for Title X were incorporated in the HRSA program management/program support line.

In FY 1988 and FY 1989, this changed, with the funds for Title X administrative expenses incorporated within the "Family Planning" line item. As the only HRSA program treated in this manner, Title X's funding picture becomes confused and is inaccurately portrayed. A return to the previous system is fully warranted.

(4) Repudiate the inappropriate administration of the Title X family planning program by the Office of Population Affairs, and resist all efforts to compromise the quality, confidentiality, or scope of Title X services.

While struggling with draconian budget cuts, Title X providers also have had to contend with inappropriate management and improper harassment from DHHS' OPA, the federal office charged with administering the national family planning program. Through a series of inapt efforts to substitute political ideology for statutory requirements, the resources of DHHS have been misappplied to undermine the delivery of high quality family planning services to millions of low-income women and teenagers.

I raise these concerns about the management of the Title X program before you today because NFPRHA understands that, as the officials responsible for appropriating millions of dollars in federal monies, you have a fundamental interest in seeing that those funds are put to work in an efficient and appropriate mannner.

(5) Appropriate funding for the Center for Population Research within the National Institute of Child Health and Human Development at least at last year's appropriation level of nearly $129 million. In addition, appropriate an additional $10 million fo the specific development and evaluation of new or improved contraceptives as per thw provisions of S. 110.

Women and men in the United States have fewer contraceptive options available to them than are available to individuals in Europe and even in many less-developed countries. Current contraceptive methods are inadequate. None are 100 percent effective, all have some side effects or are difficult or unpleasant to use. Federal funding for contraceptive research and development has not kept pace with inflation. Title X agencies serving the most vulnerable in our population need to be able to provide better, more diverse contraceptive options to their patients.

SUMMARY

Despite serious administration attempts over the past eight years to undermine it, the successes of the national Title X family planning program cannot be ignored. They speak forcefully for the reauthorization of Title X for three years and for NFPRHA's request that this subcommittee and Congress approve an appropriation for Title X of $177,515,000 for fiscal year 1990. Adequate funding of family planning and contraceptive research programs will send a strong message that Congress and this committee hold reproductive health care as a high priority, even in these times of fiscal constraint.

Thank you very much for your consideration of NFPRHA's requests. I would be happy to answer any questions you may have.

Senator **Harkin** [presiding]. Thank you very much for testifying on behalf of the National Family Planning and Reproductive Health Association.

About $177.5 million is what you are asking for, and I assume no block grants; correct?

Mr. **Swirling**. Absolutely not.

Senator **Harkin**. Thank you very much, Mr. Swirling.

Mr. **Swirling**. Thank you, Mr. Harkin.

STATEMENT OF MORGAN DOWNEY, DIRECTOR, GOVERNMENTAL AND LEGISLATIVE AFFAIRS DEPARTMENT, AMERICAN SPEECH-LANGUAGE HEARING ASSOCIATION

Senator **Harkin**. I would like to go back now and call Mr. Morgan Downey.

It is not Morton Downey, is it? [Laughter.]

Director of Governmental and Legislative Affairs Department of the American Speech-Language Hearing Association.

Good to see you again, Morgan.

Mr. **Downey**. Thank you, Senator. It is nice to see you again. Thank you for the privilege of testifying before the subcommittee.

It is not Morton Downey.

Senator **Harkin**. I know. I see that. I am just kidding you.

Mr. **Downey**. That has come up.

Senator, if I may I would just like to summarize our statement on behalf of appropriations for the National Institute on Deafness and Other Communication Disorders. As you know, you had a leadership role in enacting this institute last year. It is going to serve more than 24 million Americans who have various communication disorders. A lot of those receive services under other Federal programs, and this is the institute that is going to be the flagship for research in this area.

We think that there are three particular reasons why this is an historic opportunity for Congress to significantly increase funding for communication disorders research.

First, there is a whole cadre of students in training programs in otolaryngology, speech language pathology, audiology, and other disciplines that is excited about this new institute and are enthused by the direction of research activity in this area. We want those people to decide to make careers of research in deafness and communication disorders, and we want their interest sparked by this legislation to continue.

Second, under the leadership of the acting director, Jay Moskowitz, with the support of Dr. Wyngaarden, there is a high degree of excitement and cooperation among the numerous groups of professionals and consumers which are part of the constituency of this institute.

I have had the privilege of representing ASHA for some 11 years, and I have never seen the community so committed to an entity like this. They are enthused by the leadership and direction it has taken so far. I think it bespeaks of many opportunities for a great deal of collaborative work in research and education that is the goal of the institute.

Third, the institute is going to provide a vehicle for tackling some particularly troublesome problems that have been avoided in the past many years. One of those is the area of multicultural research needs both in terms of the multicultural populations that have various distinguishing communication disorder problems, but also we are hoping that this institute starts with a very firm commitment to the training of minority researchers in the field of communication disorders. That is an urgent need.

Second, as you know, the authorizing legislation called for the establishment of data banks and an information clearinghouse. The need for accurate demographic information in these areas is a critical one that we think the institute is particularly well positioned to affect; therefore, the association would like to ask Congress for an appropriation of $130 million. We think Congress built the ship last year. It is a seaworthy vessel, and the time has come to launch it on the right course with full wind in its sails and get this whole area of research moving along.

With that, I would like to conclude my remarks, Senator.

Senator HARKIN. Thank you very much for your testimony. I have had a close working relationship with ASHA, and we had NIH up last week. Dr. Moskowitz was there, and I think things are going reasonably well with the institute. They have a number of projects that they have embarked upon right now.

So I do not know what funding level we will be able to give to them, but it will certainly be no less than last year. Beyond that, I do not know. We will have to see.

Mr. DOWNEY. I appreciate that, Senator, very much. Thank you.

STATEMENT OF LORRAINE JORDAN, CRNA, MS, AMERICAN ASSOCIATION OF NURSE ANESTHETISTS

Senator HARKIN. Our next witness on our agenda today is Lorraine Jordan, who is representing the American Association of Nurse Anesthetists.

Welcome to the committee, Ms. Jordan.

Ms. JORDAN. Thank you. It is a pleasure to have an opportunity to address you this morning.

I would guess within the last few years you have had a family member who has had an anesthetic administered. Chances are that that anesthetic was administered by a nurse anesthetist. We administer over 50 percent of the anesthetics in the United States today.

However, that percent escalates even more in your State, since you are from a rural area in which we administer over 70 percent of the anesthetics today.

I am representing a group of individuals, the American Association of Nurse Anesthetists, which has approximately 24,000 members. I am director of education and research for the American Association of Nurse Anesthetists. I am Lorraine Jordan.

Financial appropriations are of utmost importance to nursing anesthesia. The need for increased resources is essential to secure the educational future for nurse anesthetists. I am here today to ask for funding for extending nurse anesthesia trainee programs and obtaining financial support for nurse anesthesia educational programs and schools to plan, develop, and operate the programs.

We are requesting appropriations at a full level of the authorization, which is at $1.8 million.

Why is there a need? We will hear some statistics to exemplify the need. Ten years ago we were graduating well over 1,000 students a year. Today, we are graduating only 500 or a little over. The number of vacant positions has escalated. I cannot tell you the number of calls I and other program directors get every day to try to fill these positions.

We have over a 50-percent increase in the vacant positions as well as in our news bulletin alone. In this one we have an advertisement for positions of over 300.

At different State levels, North Carolina just did a study, and they have a vacancy of 108 positions. In the next 3 years, they are estimating over 300 vacant positions. In Ohio, there are five nursing anesthesia programs, and there are over 100 vacancies presently today.

I am asking you to continue funding the nurse anesthesia traineeships. Our students go to school for 24 to 36 months and must go to school full time. It is difficult for them to supplement their income.

As I have already mentioned, we need to look for funding to start and expand our programs. Our programs have gone from 194 programs to 84 programs in the last 10 years. This drastic decrease has impacted on the supply that we can offer the health care delivery system.

Presently, we have over three applicants for every one position, and we estimate that we need at least 15 programs within the next 3 years.

PREPARED STATEMENT

I urge this committee to consider full funding for the nursing anesthesia provisions of the nurse education amendments at $1.8 million.

I would be happy to answer or address any questions you may have.

[The statement follows:]

STATEMENT OF LORRAINE JORDAN

My name is Lorraine Jordan. I am a Certified Registered Nurse Anesthetist (CRNA) and program director of the Manley L. Cummins School of Nurse Anesthesia at S.E. Alabama Medical Center. we are most appreciative of the opportunity to address the Appropriations Subcommittee on Labor, Health and Human Services, Education, and Related Agencies regarding the CRNAs' education neeeds, the shortages of CRNAs that currently exist and our Fiscal Year 1990 funding requests for these programs. Specifically, **we believe $1.8 million** should be appropriated for **nurse anesthetists education programs**. This will afford us the opportunity to recruit and retain CRNAs in the field, and provide an adequate supply of anesthesia providers.

BACKGROUND: NURSE ANESTHESIA TODAY

Currently, there are 20,500 active CRNAs providing quality anesthesia care to more than fifty percent of all patients undergoing surgical or other medical intervention which necessitat the services if an anesthetist. In addition, CRNAs are now and have been providing seventy percent of anesthesia care to rural America.

Anesthesia care is provided in conjunction with other types of health care and, as such, must complement the care of other health care providers. CRNAs work in a variety of practice patterns -- as hospital employees, as employees of physicians of physician groups, and as private contractors. Our salary is, in most instances, higher than our nursing colleagues, but pales in comparison to our physicians counterparts. The average salary of an anesthesiologist is about two and a half times ours. Yet, the quality of care provided by CRNAs confirmed by all studies done to date, is equal to that of other anesthesia care providers.

Our practice, which has existed for more than 100 years, is based on a substantial foundation of academic theory and clinical practice. As independently licensed health professionals, CRNAs are responsible and accountable for their respective practices. We also have one of the most rigorous continuing education and certification programs among all health professionals.

SHORTAGE OF CRNAs:

The field of nurse anesthesia is experiencing a shortage now and without appropriate intervention, we expect it to continue into the future. The factors contributing to the nurse anesthesia shortage are:

- the overall decline in the number of students enrolling in nursing generally:
- the "shortage" of critical care nurses;
- the decreasing number of Nurse Anesthesia Schools in the country, and;
- the decline of student positions or slots available in nurse anesthesia schools (there are three times as many applicants to each position available).

About eleven years ago (1978) there were 1,063 nurse anesthesia students graduating per year. This year, our data indicate that there will be only 630 nurse anesthesia students graduating. Attachment number one shows the drastic decline in both the number of schools and students over the last ten years.

Based on our data, there are over 500 less nurse anesthesia providers being graduated than ten years ago. Very simply, the supply is not keeping up with the demand.

HISTORY:

Last year we successfully obtained an authorization in the Nursing Education Amendments of 1988 that the authority to:

- extend the nurse anesthetist traineeship program for both students and faculty, and;

- obtained financial support for schools that would help meet the cost of projects to plan, develop and operate schools of nurse anesthesia.

Together, the authorization level for these two programs is $1.8 million. **We are requesting an appropriation in 1990 at the level of the full authorization -- $1.8 million.**

NURSE ANESTHETIST TRAINEESHIP PROGRAM:

Nurse anesthesia programs are an intense, non-stop 24 to 36 months in length. Because of the required clinical time, nurse anesthesia students very rarely are able to hold a job while in school.

In order to become a nurse anesthetist, the person must hold a current license as a Registered Nurse and demonstrate a minimum experience of one year in critical care nursing. The applicant must also hold a Baccalaureate degree in nursing or in a related field.

PROGRAMS OF NURSE ANESTHESIA:

In addition to funding traineeships for students, our biggest concern is the lack of sufficient numbers of education programs to educate our students.

The number of nurse anesthesia schools has declined significantly since 1976 when there were 194 programs, to a total of 84 in 1989.

The primary factors causing the closing of these programs include:

- cost;
- the future effect of the Prospective Payment System on the hospital's fiscal stability;
- the potential of the Medicare Graduate Medical Education pass through monies for nursing to decline, and;
- efforts by the medical community to discourage co-existing of Anestheiology Residency Programs and Nurse Educational Programs within academic health centers.

This is a new program for nurse anesthesia and we envision this program operating similarly to the Nurse Practitioner and Nurse- Midwives Program whereby grants can be given to entities for the planning, development and operation of new educational programs or to expand such programs. The number of nurse anesthesia programs needed at a Masters level is about fifteen new programs over the next three years. This would help produce an adequate supply of nurse anesthetists.

The average nurse anesthetist program can only accommodate about seven or eight students per class. A minimum of 800 hours of the actual administration of anesthesia and at least 450 patients is required in order for a nurse anesthesia student to qualify for the nurse anesthesia certification exam. The average student has over one thousand hours of clinical experience, and administers 600 anesthetics to patients.

Estimates show that start-up costs for a new nurse anesthesia program requires about $200,000 to $265,000 for the first two years of operation. Two years would allow the school to be fully operational and obtain accreditation status. With full funding, we are confident that we could open at least four new nurse education programs.

NURSING RESEARCH:

As a member of the Nurses' Coalition for Legislative Action, we wholeheartedly support the recommendations made in the attached brochure. Noting that research - is our basis for practice we support and recommend that the committee fund the National Center for Nursing Research at $38.625 million.

SUMMARY

We urge the Committee to favorably consider our recommendations. These include:

- $1.8 million to fully fund the nurse anesthesia provisions of the nursing education amendments;
- $107.9 million to fund federal nursing education;
- and, $38.625 million for the National Center for Nursing Research.

On behalf of the AANA I would like to thank this committee for all of the support in the past, particularly in assisting us in obtaining a manpower study at the Department of Health and Human Services. I would be happy to answer any questions that you may have.

STUDENT AND EDUCATIONAL PROGRAM DATA

	Total # Graduates	Total # Programs
1976	1094	194
1977	1029	166
1978	1063	172
1979	1078	163
1980	1023	161
1981	1055	148
1982	1107	142
1983	985	137
1984	953	127
1985	722	112
1986	722	104
1987	720	99
1988	574	84
1989	636*	80*
1990	693*	78*

*Projected

Senator COCHRAN [presiding]. If we are unable to come up with the funding that is requested, what are the practical implications as far as you can tell from your experience?

Ms. JORDAN. Decrease in health care delivery, anesthesia care in rural areas, especially rural areas but also in urban areas; availability of anesthesia providers. It will drastically impact the kind of health care we can deliver today and what we will be able to deliver in the future.

We are cost effective and cost efficient. It is going to increase your dollar amount spent in this health care delivery system today. I think continually we are talking about budget cuts. We are offering you an incentive to help decrease those budget cuts and give you a cost effective anesthetic.

Senator COCHRAN. Your testimony is certainly helpful to us in understanding what our options are and what the implications are for this appropriated account.

Thank you very much for being here and helping us with our hearing.

Ms. JORDAN. Thank you.

STATEMENT OF VIRGINIA MILLONIG, Ph.D., PRESIDENT-ELECT, NATIONAL ASSOCIATION OF PEDIATRIC NURSE ASSOCIATES AND PRACTITIONERS

Senator COCHRAN. Our next witness is Virginia Millonig, president elect of the National Association of Pediatric Nurse Associates and Practitioners.

Welcome to our hearing.

Dr. MILLONIG. Thank you, Senator Cochran. There are very few people that are really actually the first time around able to answer and pronounce my name correctly, so I really must commend you on that.

I am Dr. Virginia Millonig, the president-elect of the National Association of Pediatric Nurse Associates and Practitioners and really welcome the opportunity to provide some remarks today on behalf of the association.

We have three major concerns, one of them being the preventive health care of children today as well as the funding for nursing education and the funding for nursing research.

I am a pediatric nurse practitioner, as a matter of fact one of the first in the country dating back to the late 1960's and the early 1970's, and managed to practice for close to 12 or 14 years and deliver care to children, providing care in the area of treating for sore throats, minor illnesses, earaches, pneumonia, diabetes, and allergy conditions, and I also supported some developmental counseling and counseling for the adolescents as well as their parents and the school age children. So I am well aware of many of the problems that confront the parents of today.

One of the major issues that our association is concerned about is the childhood immunization program. That is the one that in spite of the funding, I believe, there has been a level funding for the programs and a zero funding for the stockpiling of the vaccines.

There is 20 to 25 percent of children who actually do not receive immunizations because of the tremendous cost associated with immunizations today, and we certainly ask your continued support in that area.

Another area that we are really very concerned with is the funding for the title 8 program, of which nurse practitioners fall under that jurisdiction. Many of our pediatric nurse practitioners that have been educated receive that education as a result of the funding that was provided through the title 8 programs. These nurse practitioners function in many other rural areas, community health centers, health departments, inner city areas, and certainly we would not be able to provide those services if we did not have those individuals and the funding that is associated naturally with them, because the funding goes to the students as well as to the programs.

The other thing that we are firmly opposed to, of course, is the Bush administration's lack of moneys for nursing education. We know desperately, of course, that the critical nursing shortage is not going to improve at all and, of course, there is a major amount of money in there that is directed toward not only nurse practitioner education but also a scholarship program. We need those enticements in order to move young men and women into the nursing profession. Otherwise, one of these days you and I are going to be in a hospital without adequate caretakers to be providing for us.

Finally, we would like to ask for funding in the area of $38 million for the Center for Nursing Research. Many of our members are involved in some of those nursing research projects, some of which are how to prevent substance abuse in our youth, how to ameliorate some of the side effects that our pediatric cancer patients are experiencing in chemotherapy and the radiotherapy that they also approve.

PREPARED STATEMENT

So in summary, we ask support for the funding for the immunization program, the funding for nurse practitioner education, and funding for the Center for Nursing Research.

[The statement follows:]

STATEMENT OF VIRGINIA MILLONIG

My name is Virginia Millonig, President Elect of the National Association of Pediatric Nurse Associates and Practitioners (NAPNAP). Thank you for your invitation to present our association's views on federal funding of programs which 1) directly affect the health of America's children , 2) ensure sufficient numbers of nurses qualified to provide a full range of nursing and health care services, and 3) ensure adequate funding for nursing research and research training vital to promoting excellence in the science of nursing.

I am a pediatric nurse practitioner (PNP) with experience providing direct services to children as well as educating PNPs. Our association represents over 2,800 pediatric nurse practitioners. Specifically, I have acquired knowledge and clinical skills in child health care through completion of a formal pediatric nurse practitioner educational program. Upon completion of this training, I sat for a day-long written examination. Passing this exam, I was certified by the National Board of Pediatric Nurse Practitioners and Associates. Certification is a confirmation of professional competency.

Pediatric nurse practitioners perform many health care functions traditionally performed only by pediatricians. For example, they perform well-child examinations, health screening measures and administer immunizations. They teach families about normal childhood growth and development, safety and nutrition, and counsel families about childhood behavior problems or family issues affecting children. In addition, PNPs assess and manage minor illnesses, such as colds, rashes, and contagious diseases, and manage chronic illnesses such as asthma, diabetes, developmental disabilities and learning disabilities. All of this is performed within the scope of practice advocated by our association and required by state law.

Childhood Immunization

Despite the many competing health issues which are important to the health of today's children, we would like to focus our remarks on the childhood immunization program. Each $1 spent to immunize a child can save more than $10 by reducing childhood illness and death from illness. However, although effective, the program does not reach 20-25 percent of the nation's children. The Administration has recommended level funding for grants to states for childhood immunization programs and zero funding for vaccine stockpiles and program operations. A recent study indicated that some families are paying nearly $120 for immunizations. Clearly, cost has become a barrier for many families. On behalf of NAPNAP, we urge greater federal efforts be made to protect our young children. We support building up vaccine stockpiles and developing programs to reach those children who do not have access to vaccines.

Access to Health Care

Our association has designated access to quality health care for infants, children, and adolescents as a priority. Many of our members currently practice in areas which are underserved by the traditional medical services team. We practice in community health centers, health departments, rural areas of the country, and in many crowded inner-city health facilities. In order to fund the advanced education requirement to become a pediatric nurse practitioner, many of our members have benefited from the federal funding of nursing education available through Title VIII of the Public Health Service Act. This law authorizes assistance for the education of nurses through both institutional support for nursing education programs and financial assistance for nursing students.

Bush Budget Eliminates Funds for Nursing Education

NAPNAP opposes the Administration's budget proposal to eliminate funding for nursing education. Along with the Nurses' Coalition for Legislative Action, representing over 200,000 professional nurses, we support appropriations for fiscal year 1990 at the level of the full authorization--$107.9 million.

The shortage of nurses and nurse practitioners is well documented. The shortage of nurse practitioners to serve in rural health clinics is so severe that Congress is considering legislation to change the rural health clinic law to require decreased participation by nurse practitioners. Among the Secretary's Commission on Nursing recommendations is increasing financial assistance to nursing students. This provision is one of many new provisions which were included in last year's reauthorization of the Nurse Education Amendments.

Today, there are fifty-one schools that educate pediatric nurse practitioners across the country--graduating approximatuly 250 PNPs a year. We are very appreciative of the support of Congress over the last twenty years in providing federal funds to increase enrollments and to assure the financial viability of nursing education programs. As you are aware, there are several specific sections of Title VIII. The Nurse Practitioner/Nurse-Midwife Program is authorized at $17 million. This increase in funds would assist us in the following ways: educate more pediatric nurse practitioners; establish innovative curricula for educating nurse practitioners; educate faculty in improved methods for recruiting and educating minority and disadvantaged students; establish educational programs in underserved areas; providing funds to students, in return for which they will provide service in underserved areas.

National Center for Nursing Research

The National Center for Nursing Research (NCNR) promotes research in nursing practice which contributes to the health of all Americans and saves health care dollars. Nursing research is aimed at finding ways to improve the care of patients. For example, many of our members are involved in research to prevent low birthweight, develop innovative approaches to prevent substance abuse by the youth of our country, and minimize the complications of pediatric cancer patients receiving chemotherapy or radiotherapy. These are only a few examples.

The Administration has recommended an increase in funding for the Center from $29.1 million in fiscal year 1989 to $30.969 in 1990. Again, NAPNAP joins with the Nurses' Coalition for Legislative Action in recommending funding at a level of $38.625 million. With the additional $7.656 over the President's request the Center could support additional research and research training.

Summary

Pediatric nurse practitioners are eager to assist in reversing the nation's slowed progress in the area of maternal and child health. In order to achieve this goal, adequate federal funding in the following areas is necessary: nursing education to assist in the preparation of adequate numbers of qualified PNPs; basic and clinical nursing research, which will yield improved techniques for nurses to care for patients; and, preventive child health initiatives, especially the childhood immunization program.

Thank you for this opportunity to appear before you today and, again, for your past support and encouragement. I would be happy to answer any additional questions.

Senator COCHRAN. Thank you very much for your testimony. I know you are aware that this subcommittee has been very responsive to the requests for support of these programs in the past, and I hope that we can continue that kind of response.

We are, as you know, today debating on the floor of the Senate the budget resolution which does have something to do with how much we are able to allocate to various areas, but it just sets broad categories of funding and it does leave some discretion, at least, for the Appropriations Committee; not as much as we would like but at least some level.

Dr. MILLONIG. On behalf of nursing and, I think, the nurse practitioners that have been educated thus far, we do appreciate the efforts and the support that we have received in the past.

Senator COCHRAN. You highlight the shortage in the nursing profession right now, and that is a serious concern to many of us in the Senate. We read about bringing nurses from overseas, some other countries, on a temporary basis to help deal with shortages. I suppose those reports are accurate. I know I was reading about the Boston area and the New York area where nurses from Ireland were being in effect imported to deal on an emergency basis with shortages.

Were those reports accurate?

Dr. MILLONIG. I believe so. There have been a number of attempts, band-aid approaches is what some of us call it, because it really is not going to take care of the long-term shortages that we are going to experience because we do not have enough of the incentive to actually encourage younger people to go into the nursing profession or even to encourage some people who were perhaps interested in other careers at one point in time to enter the profession.

The problem that I think that results from bringing the foreign educated nurse to this country, with all due respect to them, is that they really are not educated at the levels that our professional nurses are educated at, and so the delivery of care and the kind of treatment in general is very different, and they are having a difficult time trying to adapt.

I do know that the nurses from Ireland and Australia are probably those who are better prepared than a lot of the other nurses that are brought into the country.

Senator **Cochran**. Your testimony is very helpful to us. We thank you for being here.

Dr. **Millonig**. Thank you.

STATEMENT OF ANTHONY McNEVIN, PRESIDENT, AMERICAN ASSOCIATION OF COLLEGES OF PODIATRIC MEDICINE

Senator **Cochran**. Our next witness is Mr. Anthony McNevin, who is president of the American Association of Colleges of Podiatric Medicine.

Welcome, Mr. McNevin.

Mr. **McNevin**. Senator Cochran, it is a privilege to be here today, and thank you very much for the opportunity.

My name is Anthony J. McNevin. I am the president of the American Association of Colleges of Podiatric Medicine.

Senator **Cochran**. I did not do as well in pronouncing that as I did with the previous witness' name.

Mr. **McNevin**. I thought I would subtly correct the record.

As you know, Senator Cochran, podiatric medicine is a nationally recognized medical specialty that deals with the examination, treatment, and prevention of diseases, conditions and malfunctions affecting the human foot and its related governing structures.

Like physicians and dentists, the podiatric physician is licensed to make independent judgments and to administer medical and surgical treatments.

Since the beginning of the century, science and technology have combined to help us develop a far better understanding of the foot and how it works. Science has determined, for example, that in the course of a lifetime our feet bear a weight equal to 7 million tons and carry us approximately 100,000 miles. All of this activity is dependent upon one relatively small area of the body that contains one-fourth of all the bones in the body, muscles, and ligaments.

The fact of the matter is that we pay little attention to our feet until something goes wrong. That something may result in a simple strain or hairline fracture, or it could be the early warning signs of a more serious problem such as heart or circulatory diseases.

Whether the result of disease, a job-related accident, or a sports injury, all of us are vulnerable to foot ailments. We know, for example, that as many as 10 percent of all children suffer from congenital foot problems that can curtail their activities and hamper their physical and emotional development.

By the same token, we have come to realize that the fastest growing segment of our population, the elderly, also happen to be a group most at risk. For these individuals, foot problems can mean the difference between leading independent and productive lives or spending their so-called golden years enduring pain, anxiety, and limited mobility.

Today, an estimated 95 percent of elderly Americans suffer from foot disorders, and according to the National Center for Health Statistics, one-fourth of all nursing home residents cannot walk as a result of foot problems. Indeed, the hardest hit are the elderly and those who reside in rural and inner city communities.

One of the areas that requires, we hope, your attention relates to the delivery of primary foot health care. While an estimated 70 percent of the Nation's podiatric physicians have clinical privileges in one or more hospitals, the fact is that 90 to 95 percent of all podiatric physicians provide care outside the hospital setting. The challenge is now to offer the specialized education and training required to practice comprehensive podiatric foot care.

PREPARED STATEMENT

In order to help fill this gap and better prepare future physicians, particularly for the dramatic increase in geriatric care, Congress last year created a new authorization to help demonstrate the value of training primary care podiatric physicians equipped to handle the majority of foot problems particularly among those of the elderly.

With only modest funding, this program would help meet the growing need for primary health care services and help lessen reliance on more expensive specialized procedures.

[The statement follows:]

STATEMENT OF ANTHONY McNEVIN

My name is Anthony McNevin and I am President of the American Association of Colleges of Podiatric Medicine, a nonprofit educational organization.

The Association represents the Nation's seven colleges of podiatric medicine, the 232 affiliated public and private teaching hospitals, and 3,000 students and 550 residents. It also represents a growing number of continuing education programs approved by the Council on Podiatric Medical Education, with participants in each program ranging from 20 to 300 podiatrists.

Background

As you know, Mr. Chairman, podiatric medicine is a nationally recognized medical specialty which deals with the examination, treatment and prevention of diseases, condition and malfunctions affecting the human foot and its related or governing structures. Like physicians and dentists, the podiatric physician is licensed to make independent professional judgements and to administer medical and surgical treatments.

Since the beginning of this century, science and technology have combined to help us develop a far better understanding of the foot, how it works, and what can go wrong. Science has determined, for instance, that in the course of a lifetime our feet bear a weight equal to several million tons and carry us approximately 100,000 miles. All of this activity is dependent upon one relatively small area of the body that contains one-fourth of all the bones in our body, 19 muscles, and 107 ligaments.

But the fact of the matter is that we pay little attention to our feet-- until something goes wrong. That something may be the result of a simple strain or hairline fracture, or it could be the early warning signs of more serious problems, such as heart or circulatory disease, diabetes, or arthritis.

Whether the result of a disease, a job-related accident, or a sports injury, Mr. Chairman, all of us are vulnerable to foot ailments. We know, for example, that as many as 10 percent of all children suffer from congenital foot problems that can curtail their activities and hamper their physical and emotional development.

By the same token, we have come to realize that the fastest growing segment of our population--the elderly--also happens to be the group most at risk. For these individuals, foot problems can mean the difference between leading independent, productive lives or spending their so-called golden years enduring pain, anxiety, and limited mobility.

Today, an estimated 95 percent of elderly Americans suffer from foot disorders and, according to the National Center for Health Statistics, one-fourth of all nursing home residents cannot walk as a result of foot problems.

Mr. Chairman, unless there is an adequate supply of podiatrists to meet their needs, many of the elderly will be forced to postpone or forgo treatment altogether--only to require more extensive and more expensive health care later.

Mr. Chairman, it is obvious that scientific advances and new medical and surgical techniques will count for little if we lack the resources to put that knowledge into practice. Our colleges recognize that fact and are striving to prepare well-trained individuals for the profession. As a result of our efforts, the number of graduates has increased steadily over the past two decades.

During the 10-year period from 1976 to 1986, first-year enrollments increased by more than 45 percent, with minority enrollments showing the most dramatic increase-- over 220 percent.

Despite this remarkable growth rate, there are still only 9,700 practicing podiatrists in this country, or about one podiatrist for every 25,000 Americans. And although the aggregate number of podiatrists has steadily increased, the U.S. Public Health Service has characterized this as "the profession with the most serious geographic distribution problem."

The problems of supply and distribution affect us all, Mr. Chairman, but the hardest-hit are the elderly and those who reside in underserved rural and inner-city communities.

Of course, our colleges will continue to strive to help close this breach, but we cannot do it alone. These are national problems and they require a national effort.

We are most grateful to you and your colleagues on the Subcommittee for the leadership you have shown in this regard. Strong support from this Subcommittee helped launch and sustain an effort to recruit and retain students who reside in shortage areas. Since its inception 5 years ago, an estimated 260 students took part in what was called the Remote Site Training program before its authorization expired last September.

Recommendations

But challenges still remain. And one area that requires immediate attention relates to the delivery of primary care to those in need.

While an estimated 70 percent of the Nation's podiatric physicians have clinical privileges at one or more hospitals, the fact is that 90 to 95 percent of all podiatric care in the U.S. is rendered outside the hospital setting. The challenge now is to offer the specialized education and training required to practice comprehensive podiatric primary care.

In order to help fill this gap and better prepare future physicians, particularly for the dramatic increase in geriatric patients, Congress last year created a new authorization to help demonstrate the value of training primary care podiatric physicians equipped to handle the majority of foot problems, particularly among the elderly. With only modest funding, this program would help meet the growing need for primary care health services and help lessen reliance on more expensive specialized procedures.

I urge you to provide $1 million to help launch this vital program in FY1990.

Mr. Chairman, I would be pleased to answer any questions you may have.

Thank you.

Senator COCHRAN. As I understand it, the authorization is for $1 million?

Mr. McNEVIN. That is correct.

Senator COCHRAN. This is a new program? It has not been funded by the Congress before; is that right?

Mr. McNEVIN. That is correct.

Senator COCHRAN. Generally it is for use in training podiatric specialists, as I understand, in the area of geriatrics?

Mr. McNEVIN. The effort is to redirect the training of future podiatric physicians such as to emphasize comprehensive primary care rather than to emphasize highly specialized care like surgery.

Senator COCHRAN. Who will get the money? If we appropriated $1 million, who would get it?

Mr. McNEVIN. A variety of institutions would get the money because of their training activities; hospitals, universities, and colleges of podiatric medicine. They would apply for it in a competitive fashion.

Senator COCHRAN. And get grants?

Mr. McNEVIN. That is right.

Senator COCHRAN. Up to the total amount that we have appropriated?

Mr. McNEVIN. That is correct.

Senator COCHRAN. Well, this helps us understand this new program, and I appreciate your taking time to come and be with us today and to talk about it. We now know that one that is engaged in podiatry but it is podiatric medicine. We have learned that certainly today. [Laughter.]

Mr. McNEVIN. Thank you so much for the opportunity.

Senator COCHRAN. Thank you for being here.

STATEMENT OF SCOTT D. BALLIN, COALITION ON SMOKING OR HEALTH

Senator COCHRAN. Our next witness is going to talk about the Coalition on Smoking OR Health.

Welcome to the committee and please identify yourself and proceed with your presentation.

Mr. BALLIN. Thank you, Senator. I am Scott Ballin. I am vice president with the American Heart Association, but today I am here on behalf of the Coalition on Smoking OR Health, which is comprised of the American Cancer Society, the Lung Association, and the Heart Association, the three largest voluntary health groups in the United States.

The coalition urges this subcommittee to fund the Office on Smoking and Health at the level of $5 million for fiscal year 1990. In each of the past 3 years the coalition has called for this appropriation level. It is our strong belief that this proposed increase is desperately needed by the office.

The long-range goal of the Office on Smoking and Health, like our own, is to reduce smoking-related premature death and disability in the United States as well as reduce the health care costs that are associated with the cigarette habit. To this end, the Office of Smoking and Health serves as the Federal focal point for all Department of HHS, tobacco and health-related activities, and serves as an international clearinghouse for scientific, technical, and general public information regarding tobacco smoking and the use of smokeless tobacco.

In recent years, additional responsibilities have been added to the office's agenda by legislative mandate without increasing its funding levels. Among the office's added responsibilities are collecting and analyzing information on cigarette and smokeless tobacco additives, producing for Congress a biennial status report on smoking, producing for Congress a biennial report on smokeless tobacco, and staffing the Interagency Committee on Smoking and Health as well as developing educational programs and materials on smokeless tobacco.

The budget of the office for fiscal year 1989 was $3.5 million and has been flat for the past 5 years. In fact, compared to the OSH's fiscal year 1966 budget as adjusted for inflation, this important entity's budget has actually been reduced by 50 percent.

The Coalition on Smoking OR Health respectfully reminds the subcommittee that cigarette smoking is the single most preventable cause of death in the United States, and surely the Federal funding to adequately support the health promotion activities of the office is money well spent.

With the additional funds, the office could establish an ongoing surveillance program regarding tobacco use among teenagers. Our organizations are vitally concerned with the incidence of smoking found among our Nation's youth. We know that even the Tobacco Institute openly proclaims that it is not interested in encouraging tobacco use among young people.

PREPARED STATEMENT

The Coalition on Smoking OR Health is appalled by the fact that nearly 400,000 Americans continue to die each year from smoking-related diseases. We gain some consolation from the knowledge that without the work of the OSH and our own organizations and our volunteers throughout the country, the death toll could be far greater.

Thus, we respectfully request that this subcommittee fund the Office of Smoking and Health at a level of $5 million for fiscal year 1990.

[The statement follows:]

STATEMENT OF SCOTT D. BALLIN

The Coalition on Smoking OR Health, comprised of the American Heart Association, American Lung Association, and American Cancer Society, appreciates this opportunity to comment on Fiscal Year 1990 appropriations for the Office on Smoking and Health.

The Coalition on Smoking OR Health urges the Senate Committee on Appropriations to fund OSH at $5 million with 30 FTE positions for FY 1990. In each of the past three years, the Coalition has called for this appropriations level. It is our strong belief that this proposed increase is desperately needed in FY 1990.

The long-range goal of the Office on Smoking and Health (OSH), like our own, is to reduce smoking-related premature death and disability, as well as the health care costs that are associated with smoking. To this end, OSH serves as the Federal focal point for all Department of Health and Human Services (DHHS) tobacco and health-related activities and serves as a national and an international clearinghouse for scientific, technical and general public information regarding tobacco smoking and the use of smokeless tobacco. The functions of the OSH are diverse but generally fall into three categories: collection, analysis and dissemination of scientific and technical information; public education; and policy analysis.

In recent years, additional responsibilities have been added to the OSH's agenda by legislative mandate without concomitant increases in the OSH funding level. Among the Office's added responsibilities are: collecting and analyzing information on cigarette and smokeless tobacco additives; producing for Congress a biennial status report on smoking; producing for Congress a biennial status report on smokeless tobacco; staffing the Interagency Committee on Smoking and Health; and developing educational programs and materials on smokeless tobacco.

The budget of the OSH, $3.5 million in FY 1989, has been flat for the past five years. In fact, compared to the OSH's FY 1966 budget as adjusted for inflation, this important entity's budget has actually been cut by 50 percent. OSH has survived due to the transfer of scarce funds from the Centers for Disease Control's (CDC) discretionary budget. For obvious reasons, the need to rely on end-of-the-year discretionary funds has severely hampered OSH in its long-term planning abilities.

In order to reduce costs, the OSH has had to discontinue several important activities. They include: a reduction in the frequency of publication of the "Bulletin on Smoking and Health"; elimination of a compiled bibliography on smoking-related issues; elimination of a directory of ongoing research on smoking and health; and elimination of a service that compiled local media coverage of smoking-related news and issues. In addition, and of particular concern to our organizations, the OSH has been forced to significantly reduce its free distribution of the Surgeon General's reports. Limited funding is also forcing the OSH to combine its biennial status reports on smoking and smokeless tobacco use.

We are concerned that if additional funding is not now provided, then several additional more high impact activities will also be cut. Without additional funding, we may well witness: the elimination of the Surgeon General's reports or a diminution in the quality of those works; the elimination of a major health promotion education program, which encourages our nation's youth to not smoke; and/or the demise of a major research program, which is now beginning to analyze the data that will serve as the basis for future health promotion and disease prevention efforts.

The Coalition on Smoking OR Health respectfully reminds the Committee that cigarette smoking is the single most preventable cause of death in the United States. Surely, Federal funding to adequately support the health promotion activities of the OSH is money well spent.

As long as the OSH receives a FY 1990 appropriation of $5 million, it will not be required to discontinue any ongoing activities. If a small amount of additional money were to be appropriated, however, much more could be done.

For example, with additional funds, OSH could provide significant support and assistance to state health departments. Already, the Federal government, through the CDC, provides financial support to states to operate programs related to immunizations, tuberculosis, sexually transmitted diseases, and other public health concerns. These programs have yielded significant public health benefits. Similarly, a tremendous return on investment could be anticipated from the Federal funding of a coordinated anti-smoking public health campaign operated in the 50 states. At a minimum, such funds could help ensure the establishment of an Office on Smoking and Health in each state -- something that now exists in only a few states.

With additional funds, the OSH could also establish an ongoing surveillance program regarding teenage tobacco use. Our organizations are vitally concerned with the incidence of smoking found among our nation's youth. We know that while even the Tobacco Institute openly proclaims that it is not interested in encouraging tobacco use among the young, each day, an estimated 3,000 children and adolescents smoke their first cigarette. Additional monies would permit the OSH to thoroughly analyze the attitudes of teenagers as regards smoking on an ongoing basis. (As mentioned earlier, OSH is now undertaking the first survey of teens in the past ten years.) With more current, up-to-date information, volunteer organizations, like our own, might be able to establish intervention programs that will, if not ensure that they never start smoking, urge children to stop smoking before they are addicted.

A plethora of other new activities could be funded with additional monies. A clearinghouse of public information materials could be established. Additional coordination between the Federal government and private entities could take place. But this will only occur with additional funds. Without a budget increase to at least $5 million in FY 1990, OSH, as we know it, cannot be expected to continue to exist.

The member organizations of the Coalition on Smoking OR Health are appalled by the statistic that nearly 400,000 fellow citizens die yearly from smoking-related disease. We gain some small consolation from the knowledge that without the work of the OSH, as well as that of our own volunteers and staff, the death toll could well be far greater.

The Coalition on Smoking OR Health urges Congress to provide adequate funding for this important health promoting entity. We strongly urge a FY 1990 budget appropriation of $5 million for the Office on Smoking and Health.

TABLE 8.—Appropriated funds and positions for the Office on Smoking and Health (OSH) (1978–87) and its predecessor, the National Clearinghouse for Smoking and Health (NCSH) (1966–77)

Fiscal year	Appropriated funds[a] (millions of dollars)[b]	Positions[c]
1966 (NCSH)	1.955	30
1967	2.144	37
1968	2.075	37
1969	2.100	35
1970	2.250	35
1971	2.156	29
1972	2.380	43
1973	1.600 (+0.306)[d]	43
1974	0.986 (+1.862)[d]	36
1975	1.028 (+0.813)[d]	35
1976	0.823 (+0.295)[d]	12
1977	1.200	12
1978	1.200	12
1979 (OSH)	2.500	12
1980	2.519[e]	25
1981	2.062[e]	25
1982	1.944	23
1983	2.098	21
1984	3.521	21
1985	3.538	17
1986	3.375[f]	17
1987	3.471	18
1988	3.466	18

[a] The difference between these figures and those in Table 9 reflect the fact that the figures in Table 9 may exclude salaries and other "overhead" expenditures (travel, postage, photocopying, etc.).

[b] Figures not adjusted for inflation.

[c] Beginning in 1980, the number of allocated "positions" was redefined as the number of allocated "full-time equivalents (FTEs)." FTEs allow the hiring of more than one person for a given FTE (e.g., two half-time employees for one FTE), which was not possible under the previous system.

[d] Additional funds transferred from other agencies.

[e] An additional 10 million dollars was appropriated to support a smoking and alcohol demonstration grant program for children and adolescents. This money was later transferred from the Office on Smoking and Health (which at that time was within the Office of the Assistant Secretary for Health) to the Centers for Disease Control.

[f] A total of 3.526 million dollars was originally appropriated, but 174,000 dollars were withheld ("sequestered") pursuant to Section 515 of Public Law 99-190.

SOURCE: Office on Smoking and Health (unpublished data).

FROM: Reducing the Health Consequences of Smoking, Report of the Surgeon General, 1989, p. 518.

Senator **Cochran**. I appreciate your testimony and am learning more about what the Office of Smoking and Health does. I have had some personal experience in trying to quit smoking, so I have sympathy for those who got hooked at an early age on tobacco. It is a tough thing to do.

I can remember, though, there is a U.S. Lung Association. I want to put in a plug for them with you. I do not know how much money they get or what their sources are. I know that they are on the usual United Givers Fund list in communities throughout the country, but without a lot of money to advertise their program they do a lot of good. They have a program here on Capitol Hill, and that is one way you can——

Mr. **Ballin**. Is that the American Lung Association?

Senator **Cochran**. Yes; I thought it was United States, but it is the American Lung Association. There are chapters in every State, and the District of Columbia chapter that operated a quit smoking program here on Capitol Hill. I am a successful graduate of that program.

Mr. **Ballin**. Oh, great. That is good.

Senator **Cochran**. There are programs that are very helpful. I know many of them that are commercial programs that are in it to make money as well as for people to quit smoking; but this is a noncommercial program. I think it costs $35 or something to sign up.

Mr. **Ballin**. It is a tough endeavor because every day 3,000 children try cigarettes for the first time, and trying to keep them from starting is what our ultimate goal should be. That is a difficult task.

Senator **Cochran**. Well, that is difficult because there is a lot of peer pressure to learn to smoke today as there was when I learned to smoke, and you really have to try hard to learn, and you end up having to try hard to learn to quit. That is what it amounts to.

Well, thank you very much for being here, and I hope we can be helpful.

STATEMENT OF LARINA LUZZI, AMERICAN SOCIAL HEALTH ASSOCIATION

Senator **Cochran**. Our next witness is Larina Luzzi with the American Social Health Association.

Welcome.

Ms. **Luzzi**. Hello. Thank you. I am Larina Luzzi of the American Social Health Association, the only national nonprofit organization dedicated solely to the control of all sexually transmitted diseases, including AIDS.

Since 1981, the attention of the Nation has been riveted on the AIDS epidemic. As a consequence, many other public health programs have made sacrifices. Other sexually transmitted diseases which have never taken their appropriate place among the Nation's health priorities, have been almost dismissed as less dramatic, less deadly, and thus less important. We now know that these diseases are more dangerous than ever as important risk factors in AIDS.

These diseases have now reached frightening epidemic proportions in this country and demand very special attention. However, the administration requests no new funds in its fiscal year 1990 budget.

STD control programs have been confronted with multiple problems, including outbreaks of antibiotic-resistant strains of gonorrhea, tubal pregnancy, the rise of viral diseases such as herpes and human papilloma viruses, and the relationship of these diseases to infertility and reproductive problems.

When adjusted for inflation, STD controlled programs at CDC and research at the NIH have had almost no growth since 1982.

In addition, the Public Health Foundation has reported that State health agency spending for STD controlled programs had virtually no growth between 1980 and 1987. STD's have long-term irreversible consequences in women including infertility, tubal pregnancy, and cervical cancer. STD's not only interfere with the woman's ability to achieve pregnancy but also may result in death of the unborn child, prematurity, or infants born with permanent impairments.

STD's such as syphilis, herpes, and chancroid which cause all ulcers or breaks in the skin are important risk factors in the acquisition and transmission of HIV.

Adequate finding for these initiatives will require a major investment of resources. The PHS request to the department was $172 million. We can never begin to address the magnitude of the problems of STD's without significant change in the magnitude of funding.

This year, 13 million Americans will acquire a sexually transmitted disease. More than 100,000 women will be rendered sterile by an STD, and more than one-half of those women are under the age of 25.

PREPARED STATEMENT

We are witnessing the most dramatic increases in these diseases in 30 years, and the increases are almost all among heterosexuals and disproportionately among the minority communities.

We urge you to provide significant increase in funds to this critical public health crisis. Thank you for this opportunity to express our views.

[The statement follows:]

STATEMENT OF LARINA LUZZI

Mr. Chairman, I am Larina Luzzi of the American Social Health Association, the only national nonprofit organization dedicated solely to the control of all sexually transmitted diseases, including AIDS. ASHA also serves as co-chair of the Appropriations Task Force of NORA, the National Organizations Responding to AIDS. You have heard testimony from our coalition already, and I would like to begin by adding our endorsement to the recommendations presented for funding of AIDS activities.

On behalf of ASHA's Board of Directors, I want to express our deep gratitude for the support and leadership this Subcommittee has consistently shown for funding of AIDS programs and for the Sexually Transmitted Diseases Control program of the Centers for Disease Control.

Since 1981 the attention of the nation has been riveted on the AIDS epidemic. As a consequence, many other public health programs have made sacrifices. These programs are all important and worthy programs, yet they have been overshadowed. Other sexually transmitted diseases, which have never taken their appropriate place among the nation's health priorities have been almost dismissed as less dramatic, less deadly, and thus less important. We now know that these diseases are more dangerous than ever--as important risk factors in AIDS. For a variety of reasons, including the demands of the AIDS epidemic, these diseases have now reached frightening epidemic proportions in this country, and require very special attention.

Yet the Administration continues to address the AIDS epidemic to the exclusion of, and even at the expense of, research, prevention and control of the other sexually transmitted diseases. Although the PHS request to the Department for the CDC STD control program was $172 million, the Administration once again requests no new funds for this program in its FY 1990 budget.

You will be hearing from many other groups who, along with ASHA, are seeing the results of the epidemics of STDs. We maintain that these diseases must be addressed not only as a critical public health crisis in their own right, with important consequences including infertility and fetal damage or death, but as an integral part of the search for solutions to the HIV epidemic.

The problem of inadequate support for STD programs existed long before the AIDS epidemic. STD control programs have been confronted with outbreaks of antibiotic resistant strains of gonorrhea, the need to prevent pelvic inflammatory disease and ectopic pregnancy, the rise of viral diseases such as herpes and human papilloma viruses, the recognition of chlamydia, the association of some STDs with genital cancers, and the relationship of these diseases to infertility and reproductive problems. But with minimal increases in resources, and a significant diversion of personnel and funds for AIDS activities over several years, the STD control program of CDC has been forced to make difficult trade-offs and been stretched far beyond its means.

In fact, just as the AIDS epidemic was beginning, CDC had begun planning for a national chlamydia control effort including a partner notification component, which has still not been undertaken because of the demands of the AIDS epidemic. We are trying to contain a four alarm fire with a few buckets of water.

Last year's funding increase for STD control provided by this Subcommittee was the largest single increase for this program in decades. Yet, when adjusted for inflation, STD control programs at CDC and research at the NIH, have had almost no growth since 1982. (Chart 1) In fact, in real dollars, 1943 was the year of the greatest federal support for

STD control programs. In current dollars, we would have to spend $250 million to equal the federal effort in 1943, when the program consisted solely of syphilis control. Today the entire federal program to control STDs receives less than one-third that amount--to combat all STDs, some of which are reaching levels comparable to syphilis in the 1940s. In addition, the Public Health Foundation has reported that in constant dollars state health agency spending for STD control programs had virtually no growth between 1980 and 1987.

Compounding the situation is the very real problem of a "braindrain" from both STD control and biomedical research. The nation's ability to prevent and control these diseases has been adversely affected not only by the inadequacy of funds for these programs, but the loss of researchers who have turned their attentions, and their laboratories, to other biomedical research efforts where better funding opportunities exist. Moreover, the lack of funds for STD research training is having a serious long-term impact on clinical, epidemiological and basic science expertise to provide solutions to these epidemics.

Research and control of STDs is important for several reasons. STDs impact the health of women, the health of infants, and the risk of acquisition and transmission of HIV infection. Finally, they have profound importance because they are increasing in frightening proportions in this country.

STDs have long-term, irreversible consequences in women including infertility, ectopic (tubal) pregnancy, and probably cervical cancer.

STDs are preventable causes of fetal wastage, low birth weight, and congenital infection. Thus, STDs not only interfere with a woman's ability to achieve pregnancy, but also may result in death of the unborn child, prematurity, or infants born with permanent impairments. NIAID estimates that

25-50% of infants born to infected mothers are themselves infected. The dramatic increases of STDs over the past few years are harbingers of increases in congenital infections.

STDs such as syphilis, herpes, and chancroid, which cause ulcers or breaks in the skin, are important risk factors in the acquisition and transmission of HIV. Both genital warts and chlamydial infection also have been associated with increased risk of HIV infection. Further, HIV infection may complicate treatment and control of some STDs such as syphilis.

I would like to make a number of suggestions regarding programs and funding priorities for STD prevention and control efforts of CDC:

Genital ulcer disease:

Funding should be increased and directed to herpes, syphilis, and chancroid prevention and control. Particularly important are funds for epidemiologic studies to determine the risk of acquisition of HIV; to institute a genital herpes surveillance system and to expand genital herpes diagnostic facilities; to provide grants to all states to enhance traditional STD control strategies of screening, laboratory surveillance, partner notification and treatment. Also critical are funds to provide clinician training and to expand experienced disease intervention personnel.

Antimicrobial resistant gonorrhea:

Funds are needed to expand laboratory surveillance at state and local levels and to assure that states have access to reasonably priced therapy through a national contract similar to those used in the childhood immunization program.

Chlamydia:

A national chlamydia prevention and control program is imperative, and would cost at least $60 million per year.

STD control professionals:

Recruitment, promotion, training and retention of a more highly trained professional corps for STD control is critically necessary. The personnel structure of CDC should be revised to allow recruitment of more highly trained specialists.

Medical school training:

Training of medical students in STDs has been traditionally poor. Medical schools must be encouraged to increase training in STDs and to include STDs in HIV training.

Public education:

Virtually no public education programs on a national scale exist for STDs. The public must be educated about the danger of STDs and their importance as a risk factor in AIDS.

Capital improvements:

Funding is needed to improve facilities where STD services are provided, and to make these facilities accessible to people at risk, with appropriate equipment for diagnosis of all STDs.

Demonstration projects:

Demonstration projects should be established to evaluate innovative means of preventing and controlling all STDs, including HIV. Such services could include consideration of drug use, contraceptive use, and special needs of minorities with joint participation by public health and academic institutions for training.

Substance abuse:

Attention must be paid to the role of substance abuse in STDS, with adequate training for professionals and for treatment programs.

Adequate funding for these initiatives will require a major investment of resources. The PHS request of $172 million is necessary to fund these important strategies. Although that may seem like a disproportionate sum of money, it has been shown over time that the incidence of STDs responds to the commitment--or lack of commitment--of federal support. (Chart 2) We can never begin to address the magnitude of the problem of STDs without a significant change in the magnitude of funding.

Prevention and control efforts would be greatly enhanced and improved by solutions that STD research has yet to provide--such as vaccines, better and less expensive diagnostic tools, and effective treatments particularly for the viral STDs such as herpes and human papilloma viruses, which remain incurable and persistent, affecting millions of Americans.

In FY 1985 NIAID allocated $24 million to STD research projects, and in FY 1989 NIAID will spend only an estimated $32 million. In FY 1989, funding for AIDS research at the institute increased 40%, while funding for non-AIDS research realized only a 3% increase in funding. That trend will persist in FY 1990 as well.

NIAID has taken an important step in establishing its first STD Research Branch within the Institute. This should give STDs a higher profile and priority within the NIH, and permit NIAID to expand the program.

We have several recommendations for funding of biomedical research at the National Institute of Allergy and Infectious Diseases, which largely echo those presented by the 1986 STD Study Group convened by NIAID:

Research Training:

Research trainees in viral STDs and bacterial STDs must be supported. Basic training in microbiology and epidemiology has not kept pace with training in immunology and endocrinology. Postdoctoral training of behavioral scientists, very few of whom are involved in research or behavioral modification to prevent STDs, would be a valuable dimension.

STDs as risk factors:

Studies should be expanded to determine the role of STDs in the acquisition and transmission of HIV, and to determine the effect of HIV infection on the clinical manifestations of other STDs.

Behavioral research:

The establishment of a behavioral research branch within NIH could design studies to evaluate the efficacy of behavior modification for the primary and secondary prevention of STDs in high-risk populations.

Vaccine development:

Vaccines exist for only one sexually transmitted disease, hepatitis B. Vaccine development efforts must be continued with special emphasis on STDs.

Viral STDs:

High priority must be given to research on viral STDs, which affect tens of millions of Americans each year. We need to understand the nature of subclinical infection, latency and reactivation of the herpes virus. It is now believed that as many as 75% of people who have herpes may be unaware of their infection, and thus spreading it to others. Basic and clinical research are especially important on HPV, which has been associated with increased risk of cervical cancer.

Bacterial diseases:

The dramatic increases in syphilis, antibiotic resistant gonorrhea, and chlamydia in this nation are a major public health threat. Basic and clinical research on these diseases as well as their sequelae will provide important resources for prevention and control.

Centers:

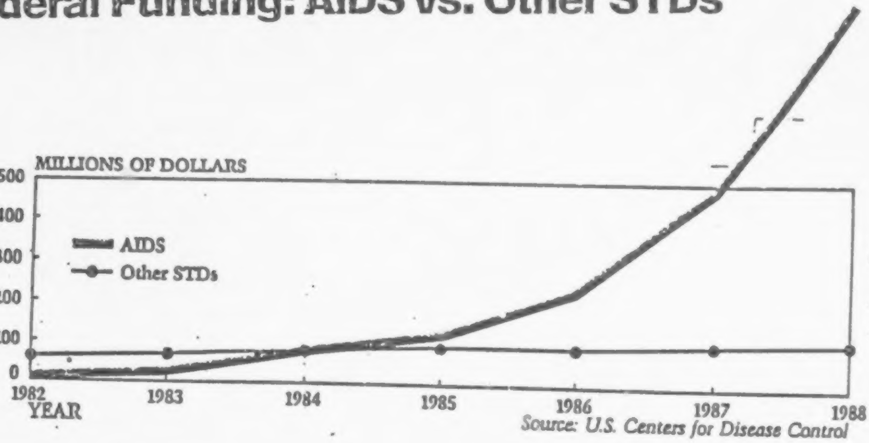
A pilot study of the center mechanism which has been effective for AIDS research should be considered for the other STDs, which would allow increased training, community outreach, and the allocation of funds locally.

Clearly, Mr. Chairman, the rationalization that diverting efforts from STD research and control to AIDS would ultimately also benefit prevention of the other STDs was a mistake, and a tragic one. We cannot continue to address AIDS without also addressing other STDs which now put millions of Americans at higher risk of acquiring HIV. In fact, Mr. Chairman, it could be argued that there is now another risk group for HIV--people infected with other STDs.

It is said repeatedly that education is the only tool we possess to prevent AIDS. But the fact is we have another critically important and cost-effective tool--control and prevention of other sexually transmitted diseases--as a method to help prevent AIDS. This will only be possible with a major investment of resources, personnel, training and facilities. We cannot afford to just keep waiting, watching, and hoping for the best. The epidemics of STDs are an overwhelming burden to our society which cannot be ignored.

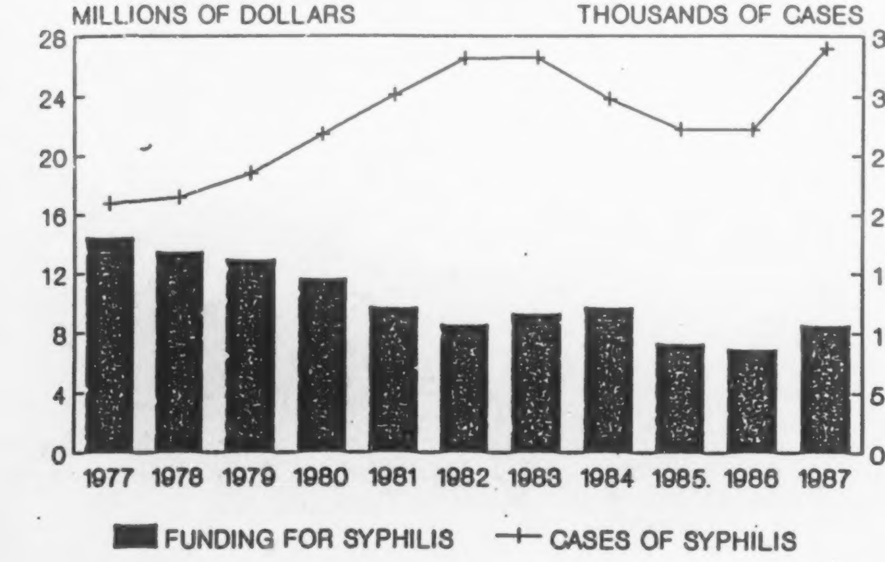
This year 13 million Americans will acquire a sexually transmitted disease. More than 100,000 women will be rendered sterile by an STD, and more than half of those women are under the age of 25. Thousands of babies will be born with STDs, and others will die. We are witnessing the most dramatic increases in these diseases in 30 years, and the increases are almost all among heterosexuals and disproportionately among the minority communities. In addition, these widespread sexually transmitted diseases are, in fact, creating a larger reservoir of infection of HIV in our society.

We urge you to continue the strong leadership you have consistently demonstrated by providing a significant increase in funds to research, education, prevention and control of this critical public health crisis. Thank you for this opportunity to express our views.



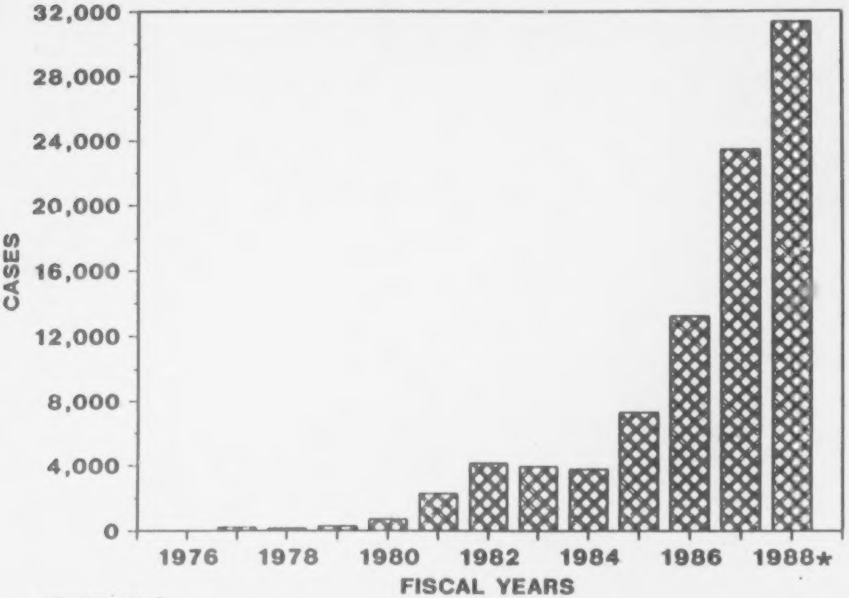
Federal Funding: AIDS vs. Other STDs

Source: U.S. Centers for Disease Control



CASES OF PRIMARY & SECONDARY SYPHILIS VS FEDERAL GRANTS TO STATES

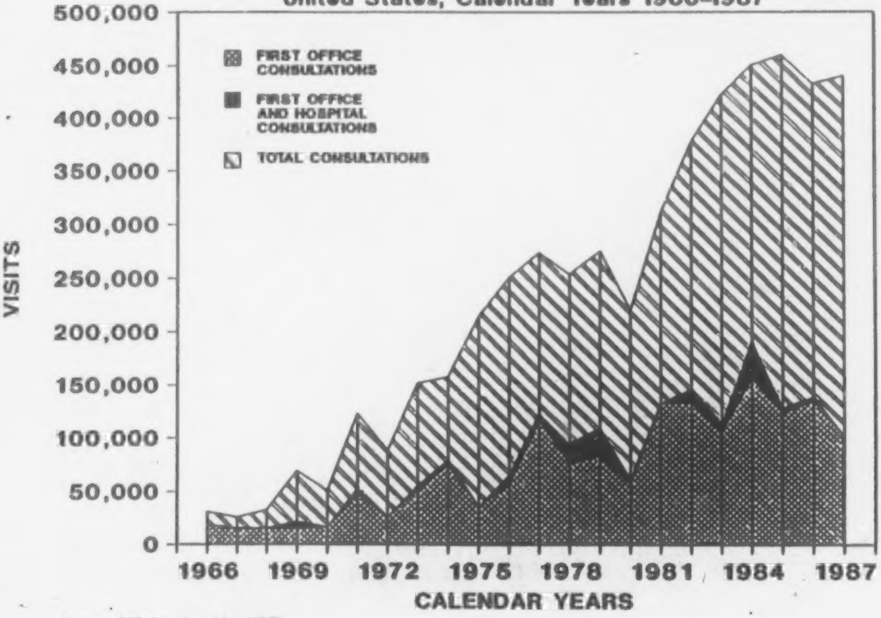
IN 1984 DOLLARS SOURCE: CDC



Resistant Strains of Gonorrhea

United States, Fiscal Years 1976 - 1988

* Estimated



Genital Herpes Simplex Virus Infections

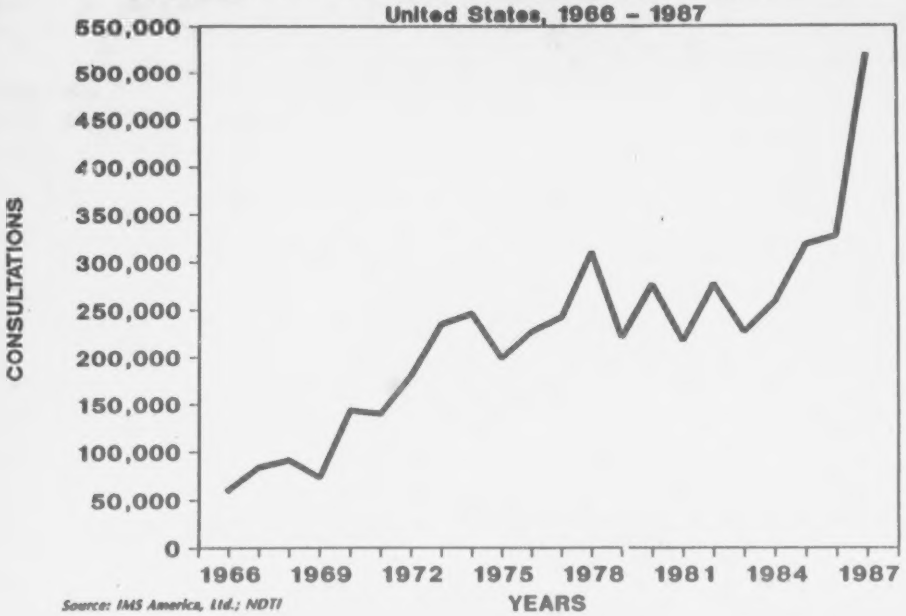
Number of Physician Consultations

United States, Calendar Years 1966–1987

Source: IMS America, Ltd.; NDTI

Genital Warts
Number of First Visits to Private Physicians' Offices

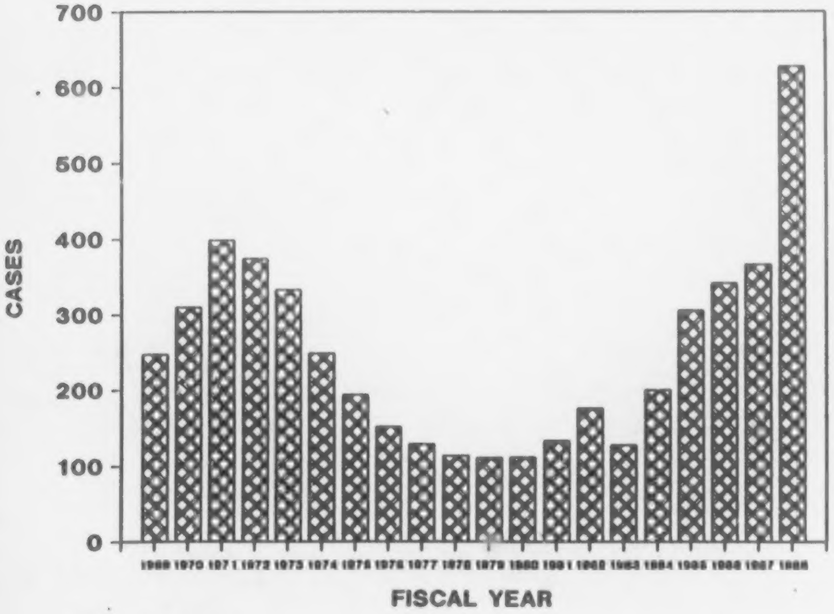
United States, 1966 - 1987



Source: IMS America, Ltd.; NDTI

Congenital Syphilis Under One Year of Age

United States, Fiscal Years 1969 - 1988



Source: CDC 73.668

Senator **Cochran**. Thank you very much for being here.

I notice that our appropriations in the last year or two for AIDS research has really gone up very dramatically because of the national attention that has been focused on that problem and the tragedy that is involved in that disease and in the lives of those who have contracted AIDS.

I wonder whether or not you would recommend that we reexamine the amount of money that is being allocated to just that one disease and maybe redirect some of it to some of the other diseases that you have discussed this morning.

Ms. **Luzzi**. It does seem that certain funds are being diverted from the other STD's to go to AIDS, and it might be at the expense of AIDS in the long run.

Senator **Cochran**. You say your organization is concerned with all sexually transmitted diseases including AIDS, as I understand it.

Ms. **Luzzi**. That is right.

Senator **Cochran**. Well, thank you very much. You have been very helpful to us.

Our next witness is Ms. Wendy Wertheimer.

Ms. **Luzzi**. Excuse me. I was here on her behalf.

Senator **Cochran**. Oh, you were substituting for her, or maybe not a substitute at all. You were the primary person. She was going to be the substitute, but she could not come. [Laughter.]

STATEMENT OF LARRY C. DEEB, M.D., DIVISION OF DIABETES TRANSLATION, CENTERS FOR DISEASE CONTROL

Senator **Cochran**. Larry Deeb is our next witness, a medical doctor who is representing the Division of Diabetes Translation.

Welcome.

Dr. **Deeb**. Thank you, Senator. I have prepared my testimony and submitted it. In the interest of time I will just highlight a few points for you this morning. The U.S. Public Health Service in its objectives for the year 2000 for the first time included chronic diseases. I would point out to you that 70 percent of deaths in the United States today are from chronic diseases, one of which is diabetes.

Diabetes is the leading cause of new blindness in the United States. It is estimated that over one-half the people on renal dialysis by the turn of the century will have diabetes. Two-thirds of all nontraumatic amputations occur in people who have diabetes.

The diabetes program at the Centers for Disease Control is now a decade old. Its success, I believe, is directly related to the efforts of this committee. It has consistently funded that division. A new Center for Chronic Diseases was created by Dr. Mason, who is chief at CDC. This Division of Chronic Diseases, again I would submit to you, is here because of the success of the diabetes division, or the Division of Diabetes Translation.

In this time of tight funding, agencies including the National Diabetes Advisory Board, the American Diabetes Association, and several State health agencies have looked very critically at CDC's diabetes program and would relate to you their recommendations collectively. That is, for operations this committee approve $2.2 million, for State programming $5.3 million, and full funding for the Diabetes Translation Center at CDC within the Chronic Disease Division of $14 million.

I think that I can document from our State, Florida, that we have made dramatic improvements in public health programming and prevention which you must have if we are going to get in the middle of this blindness, renal failure, and amputations. We have quadrupled the rate of eye examinations in public health programming in Florida.

We have a retinopathy task force which for one of the first times get optometrist and ophthalmologists working together to prevent blindness.

PREPARED STATEMENT

I would submit to you that these kind of efforts through public health programming through the CDC Diabetes Translation Division can continue to improve our fight against diabetes. I would encourage this committee's continued support and funding.

[The statement follows:]

STATEMENT OF LARRY C. DEEB

Mr. Chairman, I appear today on behalf of the Division of Diabetes Translation at the Centers for Disease Control (CDC). Non-communicable diseases represent 70 % of the mortality in the United States. Although other conditions are currently in vogue, that 70% of Americans die with chronic diseases cannot be dismissed lightly. In recognition of this fact, prevention of this morbidity and mortality has been specifically included as new priority areas in the Year 2000 Objectives of the U. S. Public Health Service (USPHS). Furthermore, I believe that the demonstrated success of the diabetes program at CDC convinced the then director, Dr. James Mason, that CDC could have a significant role in controlling noncommunicable or chronic diseases. Dr. Mason recommended the creation of a new Center for Chronic Diseases.

The diabetes program at CDC in now a decade old. This program has undergone careful evaluation at the federal level through the National Diabetes Advisory Board. It has also been evaluated by voluntary agencies, including the American Diabetes Association. I represent a State Health Agency at these hearings. It is the unanimous opinion of these individuals that I echo today in asking you to fully fund the Division of Diabetes Translation. I think it is critical that you realize this division has been given careful scrutiny by all the individuals interested in diabetes. My request for funding is for $2.2 million for operations, $5.3 million for State programs and $14 million to fully implement the Division of Diabetes Translation. I recognize that to ask for increases in funding during these times is to ask a lot, but I believe the CDC program is ready and these requests are needs based and opportunity driven.

Although the need is national in scope, I feel most qualified to give examples from our experience in Florida. Since diabetes is the leading cause of new blindness in adults, CDC has rightfully focused significant energy in battling this complication. The Florida Diabetes Control Program documented that less than 10% of patients in its primary care program were receiving sensitive eye examinations. The Diabetes Control Program (DCP), working with the centers and calling on willing expertise of professionals in Florida, was able to increase the examination level to 42%. Although this increase is significant, the DCP, like any good public health program, examined reasons for the lack of total success. All individuals could not or would not visit eye care specialists. The DCP has begun a two pronged attack. Firstly, primary care physicians are being trained in eye examinations; secondly, a Diabetic Retinopathy Task Force has been created that involves all the significant agencies, including ophthalmologists and optometrists and the State Agency for the Blind. This task force has further drawn together vital interests in eye care. The Task Force is active at the local level, utilizing individuals and agencies to help everyone with diabetes get quality eye care. To date over 1800 referrals of persons with diabetic retinopathy have occurred. The activities of the DCP in Florida are critical to the initiation and continuation of the Task Force.

The new CDC Division of Diabetes Translation, which was created last year by the Congress, based on the National Diabetes Advisory Board's Report, has taken the demonstrated need and seized the opportunity to cooperate in a multi-state follow-back of patients seen by the State Diabetes Control Programs to more fully understand reasons for failure to obtain adequate retinal care. These findings will again be placed into Public Health programming. That the Division now exists will allow CDC to conduct this sort of investigation for the first time. This opportunity to further translate the known preventative, laser treatment for diabetic retinopathy, into community practice is why the Division of Diabetes Translation exists. The National Institutes of Health (NIH) does the research and in this case everyone agrees on the treatment. The need is the creative effort to implement treatment in local communities. I believe that we, with help, have shown some of the creativity at improving care. Much more must be done, and working together, we can do it.

Diabetes is also a leading cause of kidney failure and leads to renal dialysis. Our program has demonstrated that with proper education, we achieve almost complete cooperation from health care professionals in recommended screenings for kidney disease in people with diabetes. We also have documented significant reductions in blood pressure, since hypertension is known to increase the risk for kidney damage.

Likewise, since one-half of the non-traumatic amputations occur in people with diabetes, careful foot examinations are critical. Our DCP has also shown significant increases in foot examinations in primary care centers who participate in our diabetes program.

At the present time the Division of Diabetes Translation at CDC has again recognized these needs and taken the opportunity to begin important studies looking at early signs of kidney and foot disease. These findings, which might be used to implement programs to diagnose these complications at an even earlier stage, are another example of the utility of the Division. Again the partnership of the State Health Agency and CDC should produce exciting results. This can only continue with adequate funding.

The previous administration recommended placing the current State portion of the Division of Diabetes Translation funding in the Preventive Health Block Grant. I urge you to reject this recommendation, as I feel I have documented the critical state of the Division's activities. These activities need categorical State programs with which to relate and initiate other needed activities.

Lastly, and again in the spirit of complementary review, I would urge funding of NIH, based on the recommendations of the Ad Hoc Group for Medical Research Funding. Like those interested in the Division of Diabetes Translation, this group has critically evaluated the needs and opportunities at NIH. These include a total appropriation of $8.416 billion with $667 million for the Institute for Diabetes Digestive and Kidney Diseases. I would also urge that $5 million be included for kidney disease since during this next decade it is predicted that over 50% of end stage renal disease will be due to diabetes.

I hope I have given you a sense of the current success of the Division of Diabetes Translation at CDC and its need to continue at enhanced levels. This is one opportunity we cannot afford to miss. I urge your most careful consideration. Thank you.

Senator COCHRAN. I am a new member of this subcommittee, so I am learning something about these accounts as we go through the hearings this year.

Where is the Centers for Disease Control?

Dr. DEEB. In Atlanta.

Senator COCHRAN. It is in Atlanta.

Dr. DEEB. It is a separate agency.

Senator COCHRAN. It is not connected with NIH?

Dr. DEEB. No, sir.

Senator COCHRAN. The Division of Diabetes Translation is a division of the Centers for Disease Control?

Dr. DEEB. Right.

Senator COCHRAN. So your appearance here is in behalf of the control programs especially.

Dr. DEEB. Yes, sir.

Senator **Cochran**. Public awareness, education, screening——

Dr. **Deeb**. And also public health programs reaching into the community to organize the efforts. The Diabetes Retinopathy Task Force in Florida includes the Division of Blind Services, ophthalmologists, optometrists, divotologists, primary care physicians that work together to make the public aware of this risk, get them into care and then get them treated; the whole spectrum.

Senator **Cochran**. I appreciate very much your testimony, and I know that we will try to do everything possible to support your efforts here.

I notice the proposal is to fold this program into the preventive health block grant program.

Dr. **Deeb**. Yes, sir.

Senator **Cochran**. What would your reaction to that be?

Dr. **Deeb**. When programs are at the verge of working, it is not time to fold.

Senator **Cochran**. By fold, you mean to disestablish?

Dr. **Deeb**. No, sir; but what it does is it removes that incentive to continue it as a categorical program. Really, that will do that.

The Diabetes Translation Center was funded for the first time last year. Its efforts will be diluted dramatically if this program is funded into a block grant program.

Senator **Cochran**. Thank you very much for your testimony.

STATEMENT OF DONALD COHODES, BLUE CROSS & BLUE SHIELD ASSOCIATION

Senator **Cochran**. Our next witness is Donald Cohodes representing Blue Cross & Blue Shield Association.

Mr. **Cohodes**. Senator, my name is Don Cohodes. I am from the Blue Cross & Blue Shield Association. I appreciate the opportunity to be here today.

I want to thank this committee for the support that it has expressed to us in the past for a strong Medicare administrative structure. We will need that support in the future, particularly as you listen to the balance of the testimony and my comments about the administration's proposal.

As the Senator probably is well aware, the Blue Cross/Blue Shield system is the principal administrator of the Medicare program. We handle nearly 90 percent of the claims on part A and two-thirds of the claims on part B. Some will look at the relationship between the Medicare contractors and the Government as a model of a public-private partnership. In fiscal year 1990, this partnership will save nearly $3 billion while costing the Government $1.5 billion.

If you look at it in percentage terms, the value of this investment is tremendous. It costs about 1.5 percent of total Medicare expenditures to administer the programs.

Now as we look to the future, we find that the partnership between the private sector and the Government is being challenged. It is being challenged by structural factors as well as financial factors. The structural ones have to do with the volume pressure that we feel each year. Without doing a thing to Medicare, we will face an increase next year of nearly 14 percent in claims. We will have a growing population and increase in complexity of the law due to all the legislative changes that come. Catastrophe is on the horizon. Add to that the concern about the budget deficit and the pressure on the contractor budget, and you have a very difficult situation.

Last year we were pleased to appear before this committee and to offer our support for the administration's budget request. This year, our view of the administration's budget request is significantly deficient. In fact, we believe it will challenge the integrity of the program. It will make it difficult to pay claims in a timely manner and to pay them accurately.

We want to urge this committee to recommend an appropriation of $1.748 billion with $100 million contingency. This totals about $309 million more than the administration has requested, and our differences with the administration stem largely in three areas. The first is in claims payment. Here, we recommend that $870 million be made available. This is $76 million more than the administration but equal to what the department first requested. This is to handle the increased claim volume.

For beneficiary and provider services, we are asking for $38 million more than the administration originally requested, and this is largely a consequence of our expectation that we will be seeing anywhere from 5 to 6 million new inquiries due to the catastrophic legislation and the increasing complexity of the program.

The third major area in which we have a difference with the administration is in the payment safeguard category. This committee held hearings on that subject previously, but the administration has proposed a 35-percent reduction in payment safeguard activities. Payment safeguards yield an enormous return for the Government. Depending upon the activity, which includes medical reviews, audit, and Medicare secondary payer, you get a return that ranges from $9 for every $1 spent to $20 for every $1 spent.

So the reduction proposed by the administration of $135 million will translate into a loss for the Medicare trust fund of well over $1 billion.

We recommend that the committee urge a funding level of $424 million for this function, which is $195 million above the adminstration request and $61 million above the 1989 level.

PREPARED STATEMENT

We believe the record does speak for itself that investing in Medicare administration and Medicare contractors is a good buy. It is an investment in good management, and it is an investment that pays significant dividends to the Government.

We appreciate your support in the past and we hope for it again in the future.

[The statement follows:]

STATEMENT OF DONALD COHODES

Mr. Chairman and members of the subcommittee, I am Donald R. Cohodes, Administrator of Federal Programs for the Blue Cross and Blue Shield Association, the national coordinating organization for all Blue Cross and Blue Shield Plans.

The Blue Cross and Blue Shield organization has been deeply involved in the administration of Medicare since the program began. We regard our longstanding commitment to Medicare as a model public-private partnership, providing efficient and dedicated service to the nation's largest health benefits program.

Under contracts with the Health Care Financing Administration (HCFA), our member Plans are responsible for processing claims promptly and accurately, responding to public inquiries, and performing medical review and audit activities to detect fraud and abuse and to assure only proper payments are made. Nationally, the Blue Cross and Blue Shield system handles about 88 percent of Medicare Part A and 64 percent of all Medicare Part B claims.

We appreciate the importance that this subcommittee places on maintaining a strong Medicare administrative structure. Medicare is a rapidly growing, ever-changing, and complex federal program. While the program continues to grow and the pace of change has quickened, Medicare has always relied on its contractor network to provide reliable, professional service to the public and to the medical community.

Next year alone, the Health Care Financing Administration (HCFA) projects that another 652,000 Americans will become eligible for Medicare benefits. They also estimate that a total of nearly 560 million claims — more than 2.2 million per working day — will be submitted to Medicare for payment. This means that Medicare contractors will face a 13.7 percent increase in their workload next year, even without further legislative or administrative reforms.

In addition, the contractor system has been extremely effective at safeguarding Medicare from wrongful, excessive or inappropriate payments — resulting in savings more than double the size of the contractor budget. In FY 1989, HCFA estimates just over $3 billion in Medicare benefit savings as a result of activities specifically designed to safeguard the trust funds. Indeed, almost two-thirds of the difference between our recommendation on FY 1990 contractor funding and the Administration's request is for the IRS-like audit and claims review operations which, when adequately funded, result in overall Medicare savings of about $9 for every $1 invested.

We believe that the Medicare contractor structure has served the program and its beneficiaries well over the last two decades. In total, contractor activities represent only about 1.5 percent of total Medicare expenditures, one of the lowest overhead costs of any federal program.

BCBSA RECOMMENDATION ON FY 1990 FUNDING

Last year, we testified before this subcommittee that the Administration's FY 1989 budget was adequate to pay claims according to legislated time frames and to maintain acceptable levels of service to beneficiaries and providers. However, this year we are convinced that the funding level requested by the outgoing Reagan Administration for Medicare administrative operations is entirely inadequate to meet the demands on the program in FY 1990.

We recommend that $1,748 million be provided for Medicare contractor activities and that a general purpose contingency fund of $100 million be provided as in the past for meeting unanticipated events.

Our proposal is $386 million above the FY 1989 appropriated amount and $309 million above the amount included in the FY 1990 Reagan budget. However, our recommendation to this subcommittee is also $92 million below the Department's original estimate of FY 1990 administrative needs as expressed in their request to the Office of Management and Budget.

The Administration's request fails to recognize adequately the projected growth in the program caused by a combination of the increased number of new beneficiaries and an overall increase in the number of services received by Medicare patients. And, most distressing of all, the Administration's request would leave Medicare much more vulnerable to improper or even fraudulent payments by proposing a 37 percent cut in essential claims review and audit activities. Recently, the General Accounting Office termed these cuts "penny wise and pound foolish" since billions of dollars in wasteful and avoidable spending would occur by cutting these watchdog functions. The HHS Inspector General also has testified that the President's proposed reductions would seriously impair his ability to identify and investigate those who are engaged in deliberate Medicare fraud.

THE ADMINISTRATION'S FY 1990 BUDGET REQUEST

In our view, the Administration's FY 1990 budget request for Medicare contractors is not sufficient to meet the basic needs of the program, to pay claims within the strict deadlines set by Congress, and to assure that only proper expenditures from the trust funds are disbursed.

The Administration's budget request would not be adequate for contractors to fulfill their core responsibility of paying Medicare claims promptly. Our recommended funding level of $870 million for claims processing activities is consistent with the original estimate of FY 1990 costs as determined by the Health Care Financing Administration and is $76 million above the amount included in the President's budget.

BENEFICIARY AND PROVIDER SERVICES

Medicare contracts with its intermediaries and carriers to respond by telephone and in writing to over 34 million inquiries from beneficiaries and health care providers on the status of their claims and other information on Medicare coverage and payment rules.

With the implementation of the new catastrophic limit on Part B cost sharing expense, we expect that additional public inquiries could range from 4.6 to 5.8 million calls and letters. These services are the front line activities which contractors provide directly with the public and which provide reliable answers to the numerous and often difficult questions about Medicare policy.

We recommend that an additional $38 million be provided above the Administration's request of $175.7 million for FY 1990 beneficiary and provider services.

PAYMENT SAFEGUARDS

Medicare contractors have consistently achieved billions of dollars each year in hard, documented savings to the federal budget, the American taxpayer, and program beneficiaries by safeguarding the trust funds from unnecessary and improper payments. Payment safeguard activities include auditing financial records of health care facilities, reviewing claims to determine if the services provided were medically necessary and appropriate according to Medicare's rules, and determining when Medicare is the secondary payor whenever some other source of coverage is required to pay first.

The Administration's budget would significantly reduce funding for payment safeguard efforts for a loss of $1.1 billion in FY 1990 while totally eliminating funding for over 1,100 highly trained audit staff. Just as important, the drastic 37 percent reduction in payment safeguard funding would, we believe, immediately send the wrong signal that Medicare is no longer concerned about being a prudent, vigilant payor of claims for health care services.

To maintain aggressive efforts to prevent excessive Medicare payments, we recommend that $424 million be appropriated for payment safeguard efforts for FY 1990. Our proposal is $61 million above the 1989 level and $195 million above the President's request.

Funding at our recommended level would account for the growth in claims volume next year and keeps safeguard efforts on the steady, high priority track that Congress has established in recent appropriations legislation.

CONTINGENCY FUND

In recent years, this subcommittee has recognized the volatility of changes in the Medicare program by providing for a special contingency fund for administrative operations. The Administration's request for a $100 million contingency fund would, in our opinion, be adequate to cover higher than expected workload and legislative changes that result in additional administrative burdens.

CATASTROPHIC COVERAGE IMPLEMENTATION

We support the Administration's request of $228 million for administrative costs associated with the new Medicare catastrophic coverage program. Most of these funds, $158 million, are needed to develop an entirely new claims payment system to handle outpatient prescription drug claims which Medicare will begin covering on January 1, 1991. We agree that it is extremely important to have a reliable, efficient administrative structure in place well before Medicare begins paying a portion of beneficiaries costs for medications.

CONCLUSION

In closing, we believe that the resources provided each year by this subcommittee for Medicare contractors are a sound investment in good management in one of the few federal programs with a solid record of proven, cost-effective savings. The Blue Cross and Blue Shield Association and its member Plans look forward to working closely with this subcommittee in the difficult decisions you face this year on the funding needs of the Medicare program.

Senator **Cochran**. We thank you for coming to share your views with the committee. I notice you project the 14-percent increase next year in expected claims under Medicare. Does this coincide with what the administration is projecting?

Mr. **Cohodes**. Yes; it is their number.

Senator **Cochran**. Does this mean necessarily that there should be a 14-percent increase in the appropriation for the management of HCFA?

Mr. **Cohodes**. Not necessarily, no.

Senator **Cochran**. What is the relevance, then, of the percentage increase in terms of your request for additionality?

Mr. **Cohodes**. Well, you are going to have to handle that increased volume of claims, and there is no complete economy of scale in being able to do that. You are going to have to increase the scale of your operations in a number of places, hire more people to do it. It is an indicator of the growth and the scope of the program.

Senator **Cochran**. So we do not appropriate the money to manage the Medicare program. We just appropriate the money to manage HCFA?

Mr. **Cohodes**. Yes, sir.

Senator **Cochran**. They contract out the rest, do they not?

Mr. **Cohodes**. That is correct. We are on contract to them.

Senator **Cochran**. We had them before the committee the other day, and while I was not able to stay for the entire hearing when HCFA appeared before us, there are some controversies surrounding the way the reimbursements are being made to physicians and hospitals.

Do you have any special complaints like that with administrators?

Mr. **Cohodes**. Well, no, sir. What we do for HCFA is basically handle the claim to make sure it is paid in a timely and accurate fashion and that the payment safeguard dollars, the trust fund dollars, are protected.

In terms of the policy with regard to the payment, that is established by the Government.

Senator **Cochran**. Well, you have been helpful to us, and we appreciate your insight because you do have such a large role to play; 90 percent of part A, two-thirds of part B. That is pretty impressive.

Thank you very much.

Mr. **Cohodes**. Thank you for the opportunity to appear.

STATEMENT OF CHAPIN WILSON, AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES

Senator COCHRAN. Our next witness is John M. Sturdivant, who is representing the American Federation of Government Employees. He is the national president.

Welcome, Mr. Sturdivant.

Mr. WILSON. Good morning, Senator. I am not Mr. Sturdivant.

Senator COCHRAN. You are not?

Mr. WILSON. He was not able to appear today. He had a very immediate scheduling conflict. My name is Chapin Wilson, and I am a legislative representative. I am at the American Federation of Government Employees, and we represent the vast majority of Social Security workers. Nationwide, I, in fact, work for the Social Security Administration.

We have been working on this issue for a significant number of years, and primarily that is the downsizing or, in fact, it is a euphemism for dramatic staff reductions in Social Security which result not only in harm to our own folks but also to those that we are supposed to serve. Those people by any stretch or by any reasonable standard are probably the people most dependent upon the Government for services: the aged, the disabled, children, the survivors of folks who are deceased, and, of course, folks on SSI.

We have been all around the country, and it is clear that there is a very, very serious problem with the adminstration of Social Security services. The basis of the problem and of this dramatic downsizing comes from OMB from many years ago, and it is being driven still by the Office of Management and Budget, and then the administration, of course, is carrying that out.

Now the Reagan budget and the Bush budget have left these big cuts in again for this year. We are in a state of disarray and confusion. For each of the fiscal years from 1985 to 1988, this subcommittee, and subsequently the Congress, have appropriated a lot more money for staffing than the administration in fact ended up using.

This committee and subcommittee, in fact, was instrumental and began the practice of establishing a staffing floor by statute which would require that the agency not drop below certain giving staffing levels. In conference, unfortunately, it was taken out from pressure on the House side. We are asking again that there be a statutory flow. We think that is necessary, and we are working with the House side on that.

We have gone from 86,213 work-years in 1985 to 63,911. It is a reduction of 22,000 or 23,000. This has dramatic implications and impact on how we deliver services. I did not come prepared to talk to you about Mississippi and what is happening. I did come prepared to talk about what is happening in Iowa.

For instance, one kind of small area——

Senator COCHRAN. I will tell him. [Laughter.]

Mr. WILSON. Well, I will talk to you, too, and I can get you information about Mississippi. That is, we have what are called service representatives that go out into contact stations all over the United States. They take claims out there, and they help people with their problems. There are folks who live many miles away. It is particulary important for rural States like your own.

In Iowa, just out of one district office in Creston, they have closed in the last 3 years contact stations in Shenandoah, Lamooney, Winterset, and in Red Oak. Now there are only two contact stations left. There is no more field representation, the people who know how to do this work. It is not uncharacteristic.

They send out claims representatives. In these cases they take claims. In a lot of places in the country they do not take claims anymore at contact stations. They take what are called leads. Then the people have to make an appointment and still come into the office. So the work is not being done out at the contact stations. It is an example.

Supposedly, we are saving money. The truth is, much of this is costing money. A classic example is a review of disability cases. Those folks on the rolls every so often have to be looked at.

Because cases are not being sent out from Baltimore to the field offices to be reviewed, they are being what is called rediaried. That is, the review period, the frequency, the one that is due in 1989, in Baltimore they are rediarying to 1992, so the case never gets sent out by the field for review. Large numbers of people who are able to go back to work are not being found.

Please remember that back in 1983 that is what led to this enormous debacle where lots of folks were arbitrarily thrown off the rolls because the Congress saw a problem where cases in 1979 were not being reviewed properly.

So then what happened was the administration early in 1982 or 1983 made the decision to satisfy Congress' concern by simply throwing folks off the rolls. A lot of folks died. Many people were not supposed to be thrown off, and at least 300,000 have been put back on.

We estimate that in the 1,300 field offices if only two cases that are supposed to be reviewed are not reviewed and that they found they would have been able to go back to work, over a 3-year period, which is only 2,600 cases nationwide, a small number, we are looking at approximately a cost to the trust fund of $190 million over a 3-year period. We are talking about a lot of money here.

Now the money is all hidden and the union knows about it, and the union has blocked this four times before, cases like this. Again, it is only one small one. We need to have that looked at, we need to have it stopped, and we are bringing those things to the Congress' attention.

We have several recommendations in addition to a staff of 70,000 folks. We would like to have the Congress look at the payment accuracy rate. We believe there are major problems. There is going to be a scandal one day around that. No one ever checks the agency thoroughly on what it claims its payment error rate is.

We also need to have the 800 number looked at. That has been the subject of several hearings. Senator Harkin questioned the agency recently on its problems with that, and Senator Pryor has sent a letter over. There are major problems with that, and we have documentation which we are submitting to the subcommittee which prove that the agency has, in fact, concocted a much better accuracy rate than, in fact, earlier documents which we leaked to the press indicated that they actually have.

So through this 800 number which depersonalizes service, we have seen a problem with the accuracy coming out of the agency's work.

We think there should be a continuation of the cap on the computer account because until the agency can properly administer its modernization and the telephone system is looked at in terms of its major impact on how services are delivered through Social Security, the telephone you see will be the excuse for not having to staff contact stations any longer for the removal of that face-to-face service.

That, in fact, is what the agency is already arguing. We think the Congress needs to make that decision and not a political technocrat in Baltimore. There is a very serious problem there, we think.

PREPARED STATEMENT

Finally, with respect to our people and the modernization, we should be having there ergonomic furniture. We have folks sitting all day long, 22,000 to 25,000 folks daily all day long on video terminals now; which is fine. We are not opposed to computers. We are not opposed to the use of telephones. We do think they ought to be used appropriately and properly, but there is much evidence throughout Government and in the private sector now which clearly shows that if proper furniture is not there, you end up with carpel tunnel syndrome, headaches, bad backs, eye problems, a whole range of things. Ergonomic furniture can go a long way to correct a lot of this.

So we thank you very much for your time.

[The statement follows:]

STATEMENT OF JOHN N. STURDIVANT, NATIONAL PRESIDENT, AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES

Mr. Chairman, members of the Committee, I am John Sturdivant, National President of the American Federation of Government Employees. Our Union represents the majority of workers in the Social Security Administration (SSA).

We have come before this Committee today to again focus the attention of Congress on the continued downsizing of the SSA staff at a time when the eligible client population is growing at a rapid pace and additional statutory program responsibilities have been added. Mr. Chairman, as I visit our local unions in SSA, it becomes clear that this important agency is approaching a management crisis of their own creation. The basis of this crisis is the agency's decision to solve a workload increase situation by reducing the number of people needed to perform the work at hand.

We all know that the beneficiary population growth of the 80's plus the added program responsibilities would have taxed SSA's ability to deliver quality service at the previously higher staffing levels. However, the Reagan Administration, and now the Bush Budget, have effected substantive staff cuts which have left SSA in a state of disarray and confusion.

The impact upon SSA's delivery of services has been well documented in Government Accounting Office (GAO) reports, the survey of managers in 1987/88, and our own documentation previously provided to this Committee and other appropriate Congressional Committees. Most recently, before Chairman Roybal's Aging Committee, current SSA managers again detailed the adverse impact that the staff reductions have had on themselves, their employees, and, most importantly, the senior citizens and other Americans who rely on the SSA for their economic survival.

For each of the fiscal years from FY-1985 through 1988, this Committee, and subsequently the Congress, have appropriated funds for staff at levels well above those requested by the Administration. Unfortunately, SSA has acted contrary to the

Congressional will and continued with its imprudent staff reductions. In 1985 Congress appropriated funding for 86,213 work years; in contrast, SSA's FY-1990 budget requests funds for 63,911 work years; this is a difference of 22,302 work years or a 23% reduction.

Flexibility for the Executive Branch may often be required. However, when that flexibility and discretion is used in a way that undermines the ability of a law or program to be fully and properly carried out as Congress intended, then Congressional oversight action is necessary. It is our position that the staff reductions in SSA have been depressed to a critical point. The time has come for Congress to legislate a floor instead of a ceiling for the SSA employment level. Too much is at stake for our senior citizens and taxpayers to allow this vital agency to drop into the depths of performance failure. As with Congressional action to save the Social Security Trust Fund, similar action must now be taken to revitalize the agency that administers this solemn trust.

Mr. Chairman, as you know, several years ago the Social Security Trust Fund stood on the brink of financial collapse. In a bipartisan effort, Congress forged a package that restored Social Security to financial health. All agreed this vital and important program had to be saved. Absent defense, no federal program or federal agency is more important to the American people than Social Security.

These same Social Security programs are now quietly undergoing a delivery of service crisis which jeopardizes the beneficiaries ability to properly receive the benefits to which they are entitled. This crisis has been brought about by a series of budget and management decisions that were based upon ill advised ideological criteria instead of the basic intent to properly serve the American people. If the agency is gutted and reduced to a shell, then Congress' bipartisan effort to save Social Security from financial collapse will have been in vain. This Committee and the Congress must act now to save and preserve these vital American programs from being severely damaged by the mindless reductions in staffing. This Committee has the power to save Social Security from further deterioration by providing the funds and a requirement for a statutory floor of 70,000 Full Time Equivalents (FTE). In addition, a study should be conducted, based on service delivery criteria approved by the Congress, to determine the appropriate staffing level for SSA.

A series of recent Congressional hearings has illustrated some of the outcomes of the mindless reductions in staffing and their impact on service delivery. To compensate for staff shortages, the SSA was secretly working on changes in the appeals regulations that would have made its bureaucratic life simpler, but would have had a devastating impact on claimants and beneficiaries. Action by the Congress stopped that effort. AFGE is proud to have made the SSA documents describing that potential travesty available to the Congress. The Ways & Means Committee held a hearing on the status of the SSA representative payee program, which is in a shambles. Legislation is being considered to direct the agency to correct this unfortunate situation.

Most recently, both the House and Senate Aging Committees have held hearings on the implementation of the so-called toll free 800 number as well as service delivery in general. Both Committees have found the 800 number effort to be poorly planned, poorly implemented and ill-advised. The SSA reported to this Committee that their current error rate is only 5%, down from the very high error rates reported recently in the press. However, SSA managers didn't tell you that there sample was only 150 calls per region, errors were defined as non-errors, and the employees listened to by the managers to determine the error rate were largely pre-selected. We will make the SSA documents on this matter available to the Committee.

Systems modernization is another area of concern which has received much attention. As expected, systems improvement was used for the rationale supporting deleterious staff reductions from 1985 to 1989. GAO reports that there are substantial cost overruns in the procurement of the systems and that the agency won't be able to deliver on the promises made in 1983 until the mid 1990's. At that point, the agency will be 10 years late in its software development and $1 billion over budget. The fact that this debacle was paid for by a cutback in staffing and the resultant cost of quality service to citizens is both an unsatisfactory and a sad situation.

Our final area of significant concern is the need for specific appropriations to purchase ergonomic furniture for the Video Display Terminal (VDT) users. Although the Committee had previously recommended that over 60 million dollars be used for this purpose, it did not come to pass. The approximately 22,000 VDT users now face the prospects of carpel tunnel syndrome and back problems as a result. The lack of ergonomic furniture will cause substantial numbers of workplace injuries. The cost in workmen's compensation claims and lost productivity will be more than the money needed to buy the furniture. We ask the Committee to specifically provide the funding for the ergonomic furniture and therefore prevent the worker injuries and wasted taxpayer dollars which will undoubtedly result.

In summary, all evidence points to a need for Congress to exercise increased oversight and control in the Social Security Administration. AFGE calls for:

(1) Funds to be made available to provide for a statutory staffing floor of 70,000 FTE's;

(2) An independent audit of SSA's payment accuracy rate;

(3) A moratorium on further implementation of the 800 number until recent events are reviewed and a feasibility study is concluded;

(4) Continuation of the ceiling on funds for computer and telephone systems until Congress can look more closely

into the SSA's mismanagement of systems modernization; and,

(5) Finally, ergonomic furniture be provided to all employees working on VDT machines.

On behalf of the dedicated and caring SSA employees that AFGE represents, we ask that you and this Committee stop SSA's slide towards becoming a depersonalized, uncaring adversary to those American citizens it is intended to serve.

Senator COCHRAN. I am glad to have a chance to hear your testimony. I have had an opportunity to talk with the administrator from time to time about some of these things that you bring up. I know for a fact that there are some problems with morale——

Mr. WILSON. That is very much an understatement.

Senator COCHRAN [continuing]. Among those who work for the Social Security Adminstration because they have had to cut back, and they have been under a lot of pressure to reduce expenses. This just has made a lot of them feel, maybe with some justification, that they are really overworked and not appreciated, and they get criticized fairly frequently by beneficiaries and members of Congress who end up calling them and inquiring about claims that are not paid or delays that occur in the process.

I, frankly, think that we do need to take a careful look at the appropriation for this administration, and I am hoping that we can increase the appropriation. I do not know what the 302(b) allocation is going to be. We have those problems, and you are familiar with that.

Mr. WILSON. Right. We are.

Senator COCHRAN. I do hope we can respond to some of these needs. I appreciate your taking the time to explain them and do it in the way you have done it.

Mr. WILSON. Thank you very much, Senator.

If I may make one comment about your comment about morale. It certainly is true that it is at an all-time low, and that is substantiated by our own surveys, by the agency surveys of its own managers. The managers the week before last showed up before Congressman Roybal, chairman of the Select Committee on Aging, for the first time. These managers are not retired but active. They testified that, in fact, their morale was awful, and their offices are in the Boston area.

One manager said in downtown Boston, which is his office, in each of the last 2 years he has had a 66-percent turnover in staff. It takes 3 years to train a person in title 2, your standard RSDI, and 3 years in the SSI program, with separable, very, very complicated functions.

So it is difficult to do that and to train them well and to get good work when your staff is turning over at 66 percent per year.

Our survey nationwide of offices, statistically valid, indicates that on the average any office you go into in this country, our people have told us through the study that 42.8 percent are currently looking for a job.

Now this is a very important agency. The Nation has spent a lot of time and money training these folks in a very complicated program. It is just not right to throw the baby out with the bath water.

Senator COCHRAN. I think you have made some good points, and I hope we can address those in our appropriations markup this year.

Thank you very much for being here.

Mr. WILSON. Thank you, Senator.

STATEMENT OF GARY GURIAN, MA, AMERICAN PUBLIC HEALTH ASSOCIATION

Senator COCHRAN. Our next witness is Gary Gurian, who is representing the American Public Health Association.

Welcome.

Mr. GURIAN. Thank you. Thank you for the opportunity to testify on behalf of the 50,000 member strong American Public Health Association.

Let me begin by pointing out that the administration talks about the importance of prevention but at the same time it will cut funding for critically important and basic public health programs. This comes at a time when this Nation's public health community has both the knowledge and the knowhow to, No. 1, prevent thousands of annual deaths from all too common medical problems ranging from home, motor vehicle, workplace injuries to breast, and cervical cancer. We have the knowledge and knowhow to halt the rampant spread of a resurging number of sexually transmitted diseases and to eliminate a lifetime of hardship for thousands of children exposed to vaccine preventable diseases such as hepatitis and a toxic environmental hazard of lead.

Now to help assure the public health community is able to attack these and other nagging public health problems, the non-AID's related programs at CDC should receive $880 million. CDC AID's activity should receive $600 million. Frankly, if our National Treasury could absorb the cost of the fleet of 132 Stealth bombers at a projected price tag of $500 million each, we can certainly find the resources to fully fund CDC, through whose programs the lives of millions of Americans are promoted, prolonged, and provided real front-line protection.

Turning first to immunization, we urge Congress to fund the CDC's immunization activities at $183.7 million. It is impossible to overstate the importance of immunizing our youngsters. Immunizations are among the safest, cheapest, and most effective ways to prevent infections of communicable diseases ranging from hepatitis B, to measles, mumps, rubella and polio. We ask you to fund the SED program at $172 million so CDC can enhance its prevention and control efforts.

My own city of Allentown is in the midst of an explosive syphilis epidemic. Our case rates exceed that of the Nation. The State of Pennsylvania and most urban centers of the United States have also tragically seen the reappearance of congenital syphilis in newborn infants born to infected mothers.

Turning to injury prevention, we urge you to fund CDC's injury prevention and control program at $50 million for fiscal year 1990. Again, the experience of the Allentown Health Bureau's comprehensive home and motor vehicle injury prevention program has demonstrated the benefits of physically authorizing CDC to lead a nationwide assault against the incidence of predictable and preventable injuries.

The Allentown Health Bureau program which was initiated in 1984 has revealed that the public is exposed to a plethora of injury producing environmental hazards which if identified can be corrected.

Lead poisoning: The APHA requests $22 million in fiscal year 1990 to enhance CDC's lead poisoning prevention program. The potential lifelong social and economic consequences of inadequate funding for childhood lead poison prevention is reflected in my own State of Pennsylvania. It has been conservatively projected that up to $161,000 Pennsylvania children ages 1 through 5 have elevated blood leads. Yet, in 1988, funding shortfalls resulted in only 26,000 high risk children being screened for lead poisoning.

Our association urges you to fund CDC's breast and cervical cancer initiative at $25 million in fiscal year 1990. Again, may I point to the experience of the Allentown Health Bureau which I am director of. We have found that 48 percent of the women provided mammographies for the early detection of breast cancer through the Allentown Health Bureau's project did not previously have an appropriately scheduled lifesaving mammography.

We have also found that the frequency of important regularly scheduled Pap smears for the early detection of cervical cancer decreases with age.

PREPARED STATEMENT

Turning finally to acquired immune deficiency syndrome and drug abuse, the American Public Health Association urges you to fund Federal AIDS activities at $2.1 billion to help enhance our risk reducing education prevention programs. Given the link between illicit drug use and the transmission of HIV infection, we urge Congress to also provide sufficient funding for the expansion of this Nation's drug treatment system, a system that is currently overburdened from Allentown to Anchorage and all cities in between.

APHA once again asks the Congress to take a leadership role in funding the public health programs of this Nation. Thank you very much.

[The statement follows:]

STATEMENT OF GARY GURIAN

Mr. Chairman and distinguished members of the Subcommittee, my name is Mr. Gary L. Gurian. I am Director of Health for the Allentown Bureau of Health and am here today representing the American Public Health Association, the oldest and largest public health society in the world.

I am here today to tell you that once again, the Administration's budget requests for critically important public health programs are woefully inadequate. The Administration talks about the importance of prevention, but at the same time it would cut funding for basic public health programs. The Administration knows that investing in such programs substantially reduces the expenditures that otherwise would have to be made in the future, but it would rather save a dollar today than three tomorrow.

Mr. Chairman, in light of the Administration's short sightedness we look to you and your colleagues to ensure that the less fortunate in our society have access to quality public health services.

This year alone -

> Approximately 140,000 Americans will die from injuries: 50,000 of these deaths are homicides and suicides, over 40,000 are motor vehicle related, and at least 10,000 occur on the job.
>
> About 1.8 million people in the U.S. will suffer head injuries. 50,000 of the survivors, most of them young, will experience severe long-term physical and mental difficulties.
>
> More than 50,000 women will die from breast and cervical cancer.
>
> More than 13 million Americans will contract a sexually transmitted disease such as syphilis, chlamydia or gonorrhea.
>
> Over 1,000 babies will contract herpes at birth. Half of them will die, and half of the survivors will have serious birth defects.
>
> 3,500 newborns will become Hepatitis B virus carriers and 1,000 of them will eventually die as adults from cirrhosis or primary liver cancer.
>
> Thousands of children under six years of age will be hospitalized for treatment of lead poisoning, and tens of thousands will be exposed to lead to a degree that may impair their intellectual development.

The tragedy of these shocking statistics is that we have the public health tools to deal with many of these problems.

> Most of the 7,000 cervical cancer deaths that occur each year could be prevented through screening and appropriate follow-up.
>
> 30% to 50% of all breast cancer deaths could be avoided through the widespread use of mammographies.
>
> Most of the children born to women who are chronically infected with hepatitis B virus could be immunized at birth and would not become HBV carriers.
>
> Many cases of infant pneumonia, a common cause of infant mortality, could be avoided if we screened high risk pregnant women and treated those who test positive for chlamydial infection.

The public health community is ready and willing to tackle these issues, but we need the resources.

This year, APHA is focusing its attention on immunization,the control of sexually transmitted diseases, injury prevention and control, lead poisoning prevention, breast and cervical cancer mortality prevention, the National Institute of Occupational Safety and Health (NIOSH), AIDS and drug abuse. Because of time constraints we can not mention all the important programs funded through the Centers for Disease Control. At a minimum, however, the non-AIDS related programs at CDC should receive $880 million, and CDC's AIDS activities should receive $600 million.

Immunization Program

We urge Congress to fund the CDC's immunization activities -- including grants to states, the vaccine stockpile, the National Vaccine Program, the Adverse Events Reporting System, and surveillance, research and technical assistance -- at $183.7 million.

The Administration argues that we have been 97-98% successful in our immunization efforts, but its budget request would provide inadequate funding to complete the job. Unlike the Administration, APHA's funding request of $165.9 million for state project grants would allow the States to continue immunizing children at current levels. It would also fund hepatitis screening of pregnant women and treatment of the infants of HBV positive mothers with HBIG and HB vaccine at birth. And it would allow states to deal with measles outbreaks.

Past shortages of DTP vaccine and potential shortages of other childhood vaccines graphically demonstrate the need for a six month vaccine stockpile. We ask that you provide $4 million for the stockpile.

It is impossible to overstate the importance of immunizing our youngsters. Vaccines are among the safest, cheapest and most effective ways to prevent infections and communicable diseases. Immunization returns as much as $90 for every dollar spent. The widespread use of vaccines has produced dramatic declines in the incidence of childhood infectious diseases, and with that decline has come a drop in infant mortality. Immunizing children is far less expensive than paying the costs attributable to childhood illnesses.

Sexually Transmitted Diseases (STD)

We ask you to fund the STD program at $172 million so that CDC can enhance its activities in the areas of chlamydia, genital ulcer disease, and resistant gonorrhea prevention and control.

The current resurgence of primary/secondary syphilis, chancroid, and genital herpes among heterosexuals shows that we must again target STD control measures to key populations. Chancroid increased by almost 29 percent in 1988; almost 5,500 cases were reported, the highest number since 1950. Primary and secondary syphilis cases increased by over 17 percent during FY 1988, the largest increase since 1949. Neglect of traditional STDs has reversed the positive momentum of the 1970s.

The serious complications of STDs include pelvic inflammatory disease, infertility, ectopic pregnancy, infant pneumonia, mental retardation, immune deficiencies, neoplasia, and fetal death. At least seven cancers are associated with different STDs, and STDs are a determinant of HIV acquisition and transmission.

A national strategy to control chlamydial infections was developed in 1985. Chlamydia has replaced gonorrhea as the number one bacterial STD, but without sufficient federal funds directed toward its control, the problem will worsen. Dr. Mason, the former head of CDC, testified before Congress that a national chlamydia control program will cost between $50 and $60 million.

Despite the emergence of chlamydia, herpes, human papilloma virus and the AIDS virus as priority STDs, the federal commitment to this area has declined in real dollars in the 1980s. The reductions have been foolish; for every $1 invested in interrupting transmission of gonorrhea, $3 is saved in health care costs.

Injury Prevention

We urge you to fund the CDC's Injury Prevention and Control Program at $50 million for FY 1990.

Injury is the fourth leading cause of death among all Americans, and the leading cause of death among children and young adults. It causes almost half the deaths of children aged 1-4; more than half the deaths of children aged 5-14, and nearly four-fifths of the deaths of 15-24 year olds.

For those under 35, motor-vehicle crash injuries alone are actually the leading cause of death. The societal costs of such injuries are second only to those of cancer.

Although injuries are responsible for the loss of more economically productive years of life than heart disease and cancer combined, the federal expenditure for research in injury control is approximately one-tenth of that for cancer and less than one-fifth of that for heart disease and strokes.

APHA believes that $50 million in FY 1990 will allow CDC to strengthen its integrated, multidisciplinary approach to injury prevention with the goal of reducing mortality, morbidity, disability and the costs of both intentional and unintentional injuries. Funding at this level will also allow establishment of a Center for Injury Control within the CDC, as recommended by the National Academy of Sciences.

Lead Poisoning Prevention

The APHA requests $22 million in FY 90 for CDC's lead poisoning prevention program.

Lead poisoning is the most common environmental disease among children. Almost 70% of poor, minority children in large, central-city urban areas have lead levels high enough to adversely affect their health.

Elevated lead levels in children can decrease intelligence, slow development, and produce behavioral problems. The effects on intelligence and behavior are especially harmful to children who are already disadvantaged by poor nutrition, and the other ills affecting inner city children.

We have made remarkable progress in removing lead from food and gasoline, but much more must be done to eliminate it from old house paint, dust, soil, and drinking water.

To prevent lead poisoning, we must ensure that all children with high lead levels receive appropriate evaluation and treatment. This program, if adequately funded, will screen children for elevated lead levels and assure medical referrals and environmental intervention..

Breast and Cervical Cancer Prevention

Our Association urges you to fund CDC's breast and cervical cancer initiative at $25 million in FY 90.

Among cancers, breast cancer is the leading cause of death for women under 65. Nearly two-thirds of the black women who die from breast cancer are under age 65. Now that the "baby boomers" have reached the age of greater risk of breast and cervical cancer, we expect to see dramatic increases in mortality from these two cancers unless a systematic screening program is in place.

Mortality from breast and cervical cancer can be reduced. Virtually all cervical cancer deaths could be prevented; and breast cancer mortality could be reduced 30% to 50%. CDC's cancer initiative therefore has the potential to dramatically reduce deaths from breast and cervical cancer.

National Institute for Occupational Safety and Health

Our Association urges you to provide, at least $70 million for the National Institute for Occupational Safety and Health (NIOSH).

Earlier this year, the Administration requested a decrease of $26 million in NIOSH funding. If the request is granted NIOSH will be forced to eliminate its research grant program, discontinue cooperative agreements, limit intramural research, discontinue all small training grants, eliminate most current activities relating to worker notification, phase down the Fatal Accident Circumstance and Epidemiology (FACE) program, and eliminate its respirator research program.

There are over 104 million workers in 5 million workplaces in the U.S. Approximately one out of every ten workers in private industry suffers an occupational injury annually; about four out of one hundred are disable from these injuries; and nine workers in 100,000 are killed on the job each year.

NIOSH is the only federal agency conducting research in industrial populations. If the Administration's budget is adopted, CDC will be unable to carry out much of this mission.

Acquired Immune Deficiency Syndrome and Drug Abuse

The American Public Health Association urges you to fund federal AIDS activities at $2.1 billion.

By the end of 1991 almost half a million individuals will have become infected with the human immunodeficiency virus (HIV) and almost 40% of those infected will be dead. Increasing AIDS funding will allow for needed education, risk-reduction and prevention programs. In the absence of a vaccine or other effective treatment, our only means of slowing or stopping the spread of infection is through education, risk-reduction and prevention programs that teach people how not to transmit or become infected with the virus. The funds sought by APHA would also support basic biomedical, epidemiological, psychosocial and other AIDS-related research programs. Lastly, the appropriation would provide funding for treatment.

Given the inextricable link between illicit drug use and the transmission of HIV, APHA strongly believes that we must also provide resources to deal with the problem of drug abuse. Specifically, we urge Congress to provide sufficient funding for expansion of the drug treatment system. Denying an intravenous drug user treatment, or placing him on an endless waiting list, is tantamount to being sentenced to play Russian Roulette. We strongly endorse the Presidential AIDS Commission's recommendation of a "treatment on request" system for drug abusers in the United States.

The Administration's indifference this year may be kinder and gentler, but it is indifference nonetheless. We ask that Congress once again take a leadership role in funding the public health programs. If we as a nation ignore or inadequately fund these activities, those of our citizens who are least able to fend for themselves will suffer and die from preventable disease or injuries. Please help the public health community prevent that from happening.

Thank you.

Senator COCHRAN. Thank you for your testimony.

Let me ask you. Do you think we get too much in the business of deciding exactly how many dollars go for research in one area or another? Should we not turn this decisionmaking over to health care professionals or scientists rather than making the decisions as we do here so often?

Mr. GURIAN. I think you have to listen to the advice of health professionals, particularly professionals within organizations that have a well proven track record like the Centers for Disease Control and the remainder of the U.S. Public Health Service. I think we would start getting more bang for our buck if we did something like that.

Senator COCHRAN. Well, just as a matter of curiosity, we all get requests from our fellow colleagues in the Senate to cosponsor legislation to draw attention to the peculiar problems and tragedies that are caused by a particular disease from time to time, and we either designate a week to observe or to try to stress the importance of research in a certain area, whether it is cancer or diabetes or some of these other diseases and problems.

I just wonder whether or not that is the best procedure to use or whether or not what gets on the evening news that evening—we are trying to draw public attention to these things and congressional attention. Some things are left kind of unnoticed in the crush for public attention or the pressure for attention, and I just wonder whether or not that is the way we ought to measure the amount of money we appropriate each year as how much public attention one thing gets.

Mr. GURIAN. Absolutely not, because the only thing, for instance, those weeks do is to raise public consciousness. In order to really make an impact, really make a difference, we have to take more of a systematic approach to a number of diseases.

Unfortunately, we tend to have a disease of the month or a disease of the year——

Senator COCHRAN. That is what we used to call it, the disease of the week.

Mr. GURIAN. But what happens is some of the other diseases that we thought we have licked, we find ourselves confronted with them again; to pick an example, syphilis. We have had a resurgence in infectious syphilis and its devastating complications in many urban centers across this country— —

Senator COCHRAN. HHS has called to our attention the fact that tuberculosis is continuing to be a problem and that we need to have a program for the eradication of that.

Do you support that initiative?

Mr. GURIAN. That is right. I certainly do, and the American Public Health Association certainly does.

Senator COCHRAN. You have been helpful to us, and we appreciate your taking time to be with us today.

STATEMENT OF WALTER F. LEAVELL, PRESIDENT, ASSOCIATION OF MINORITY HEALTH PROFESSIONS SCHOOLS

Senator COCHRAN. Our final witness is Dr. Walter Leavell, who is president of the Association of Minority Health Professions Schools.

Welcome, Dr. Leavell.

Dr. **Leavell**. Thank you, Senator.

I am very pleased to appear before this committee this afternoon to discuss Federal funding for health research and education as it impacts upon opportunities for minorities and health professions. The Association of Minority Health Profession Schools, founded approximately 10 years ago by Dr. Louis Sullivan, represents all of the black health profession schools in the country with the exception of the health profession schools at Howard University.

I am joined here today, I might add, by a number of the deans and the president from those institutions.

This committee has played a leadership role in assuring that adequate resources are provided to the institutions of our association and to the students who attend our schools. We want you to know that we deeply appreciate the support. However, we have a long way to go.

Still several years after the sobering report of Secretary Heckler's task force on blacks and minority health, HHS departmental resources have not been specifically targeted to deal with these problems pointed out in this report. These problems were of disproportionality in infant mortality, life expectancy, and disease prevalence in blacks and other minority populations.

The hard-won gains made in black enrollment and graduates of health profession educational programs peaked in the mid 1970's. In recent years, the applicant pool of blacks and other minorities who are seeking health profession careers has declined significantly. Federal health professions programs have had a tremendous impact on efforts to supply the Nation with qualified minority health care professionals.

For example, the Health and Minority Health Education Care Act has allowed a limited number of minority health profession schools to significantly improve their capacity to train and prepare promising students for clinical and scientific careers. Unless health professions and student aid programs are significantly expanded for minorities, the number of minority participants in health professions will remain tragically low.

It is recognized by the Secretary's task force that the health status of minorities is likely to improve with an increase in the number of minority health professions.

The strengthening programs for historically black graduate institutions is having a significantly positive impact on our institution's capacity to achieve these goals. We are pleased the President's budget proposal includes some funding for these programs and recommend the committee give consideration for full funding.

Within title 3, the graduate section 326 is designed to award program grants to postgraduate institutions that are making a substantial contribution to the medical/dental/veterinarian educational opportunities for black Americans. Four of our eight institutions participate in this program, and it has been very helpful for them to achieve this goal.

The research center's minority institution program introduced by Congressman Stokes and supported by this committee has been a very valuable mechanism for developing the research capacity of minority institutions. As a result, our institutions have now been able to compete for more traditional sources of research funding. Our association recommends a fiscal year 1980 funding level of $20 million for RCMI.

PREPARED STATEMENT

Mr. Chairman, we are appreciative of the Federal program support we have received, and we believe you are making a very sound investment and it is yielding results.

Thank you.

[The statement follows:]

STATEMENT OF WALTER F. LEAVELL

Mr. Chairman and members of the Subcommittee, I am very pleased to appear before your Subcommittee to discuss federal funding for health, research and education as it impacts upon opportunities for minorities in the health professions.

The Association of Minority Health Professions Schools is comprised of the Charles R. Drew University of Medicine and Science in Los Angeles, CA; the Meharry Medical and Dental Colleges in Nashville, TN; the Morehouse School of Medicine in Atlanta, GA; the Florida A&M University College of Pharmacy in Tallahassee, FL; the Texas Southern University College of Pharmacy and Health Sciences in Houston, TX; the Xavier University of Louisiana College of Pharmacy in New Orleans, LA; and the Tuskegee University of School of Veterinary Medicine in Tuskegee, AL. With the exception of the health professions schools at Howard University, our association represents all of the Black health professions schools in the country. Mr. Chairman, we consider these institutions a national resource that have served a significant and disproportionate role in the training of minorities in health professional careers. Similarly, because of this important role, we believe that special consideration should be made to providing federal resources to these schools that have trained 40% of the nation's Black physicians, 40% of the nation's Black dentists, 50% of the nation's Black pharmacists, and 75% of the nation's Black veterinarians.

Mr. Chairman, this Subcommittee has played a leadership role in insuring that adequate resources are provided to the institutions of our association and to the students who attend our schools. We want you to know that we deeply appreciate this support. When the Founding President of AMHPS, Dr. Louis Sullivan, first appeared before this subcommittee about 10 years ago, who would have guessed that there would be the federal commitment to minority health professions and research that there now is, and who would have guessed that HHS Secretary Sullivan would now be administering these programs.

However, Mr. Chairman we have a long way to go! Still, several years after the sobering report of the Secretary's Task Force on Black and Minority Health, HHS departmental resources have not been targeted to dealing with these problems.

FY'90 President's Budget Proposal

The President's budget proposals for fiscal year 1990 do not match-up with the commitment his administration has expoused as "kinder and gentler". In fact, the fiscal year 1990 Budget proposal looks very similar to previous budgets submitted by the last administration. Wipe out health professions, nominal increases for NIH, and nominal increases for institutional assistance and student aid.

Health Professions and Student Aid

The hard-fought gains made in Black enrollment and graduates of health professions education programs peaked in the mid-seventies. In recent years, the applicant pool of blacks and other minorities who are seeking health professions careers has declined significantly. Four major factors that have led to the decline are (1) the continued lack of educational preparedness of these groups; (2) the attraction of these young students to other less rigorous, and more financially rewarding professions; (3) large debts incurred by minorities who pursue health professions careers. For example, the average debt in 1987 of a student graduating from the Morehouse School of Medicine is $49,000, compared to $32,000 just three years ago. These numbers are staggering to all of us -- but they are overwhelming to black and hispanic students from poor and lower income families; and, (4) lack of knowledge of, and access to, the financial resources necessary to pursue a medical career.

Federal Health Professions programs have had a tremendous impact on efforts to supply the nation with qualified health professionals. For example, the Excellence in Minority Health Education and Care Act has allowed a limited number of minority health professions schools to significantly improve their capacity to train and prepare promising students in clinical and scientific careers. However, minority health professionals in the disciplines of medicine, dentistry, pharmacy, and veterinary medicine continue to be disproportionately low. While blacks represent approximately 12 percent of the U.S. population, only about 2-3 percent of the nation's health professionals are black.

Mr. Chairman, unless health professions and student aid programs are significantly expanded for minorities, the number of minorities participating in the health professions will remain tragically low. As recognized by the HHS Secretary's Task Force Report on Black and Minority Health, the health status of minorities is likely to improve with an increase in the number of minority health professionals.

Council on Graduate Medical Education

Mr. Chairman, the issue of financing of Graduate Medical Education through the Medicare system has received attention by the Council on Graduate Medical Education. COGME's important work was demonstrated in their first report to Congress last July. The Council on Graduate Medical Education's continued activities need to be supported by a distinct appropriation. Specific projects related to logistical support, the underrepresentation of minorities, geographic maldistribution of physicians, and GME reimbursement in ambulatory settings are all issues that need to be reviewed by COGME in more detail. It has been estimated that a modest $1 million annual appropriation would allow these projects to move forward.

Higher Education and Institutional Programs

Institutional programs for strengthening Historically Black Colleges and Universities are very important to the continued development of many institutions that train a great number of Blacks and other minorities. The strengthening grant programs for Historically Black Graduate Institutions are designed to establish or strengthen the physical plants, financial management, academic resources, and endowments of HBCUs. A further use of the resources for the establishment of an endowment development office or to increase contributions from private sources is a very positive aspect of the program. The strengthening program for Historically Black Graduate Institutions is having a significant positive impact on our institutional capability to achieve these goals. We are pleased that the President's budget proposal includes some funding for these programs, and recommend that the Committee give consideration to funding these important programs in FY'89 at the fully authorized level.

Within Title III, the Graduate Section 326 is designed to award program grants to post-graduate institutions that are making a substantial contribution to the medical, dental or veterinary educational opportunities for Black Americans. Four of the eight institutions of our Association are eligible for this important matching program that has helped our institutions increase contributions from alumni, the private sector, and assist in the development of institutional endowments. Program activities among our schools include Morehouse's advancement from a two year medical school to a four year, fully accredited medical school. Each school has been able to enhance the development of faculty and programs in the basic medical sciences, and expand curriculum and academic support systems, as well as improving each of our institutional research capabilities.

Funding for this important program has been modestly increasing during the past several years, and we believe that it is critical to increase the resources for this program. Certainly if additional schools were made eligible, it would be critical to provide additional dollars and protect the current level of funding for the participating schools. To decrease the commitment to the currently participating schools would be a sure recipe for failure.

Minority Research Initiatives

Now more than ever before, the institutions of our Association are becoming increasingly able to participate in biomedical research activities through the National Institutes of Health and other federal agencies. Many of our schools have made significant advances in the development of their research infrastructure and investigational capabilities. The Research Centers at Minority Institutions program, introduced by Congressman Louis Stokes, and supported by you and your Subcommittee, has been a very valuable mechanism for the continued development of the research capability of minority institutions, especially for the study of diseases and health status factors that are more prevalent among blacks than in the general population. Mr. Chairman, the RCMI program has allowed our schools to obtain state-of-the-art research equipment and supplies, hire research faculty to complement existing staff, provide faculty research development programs, create research training opportunities for undergraduate and graduate students, and fortify institutional services that support research. Most importantly, RCMI has served as a major stimulus in the ability of our schools to compete for more traditional sources of research funding. Xavier University College of Pharmacy has recently approved a Doctor of Pharmacy Program, and has subsequently received an RCMI grant. Xavier is the final AMHPS institution to receive a grant under this important program. In order to strengthen the RCMI programs at the other institutions, to provide additional resources for the new Xavier program, and to support supplemental requests, our Association recommends a FY'90 funding level of $20 million for RCMI.

We would also like to encourage your Subcommittee to explore how specific NIH Institutes could supplement RCMI programs with research funds provided by your Subcommittee, similar to the AIDS effort, and related to the disease specific missions of the individual institutes. We believe that integration of resources into these existing programs could have a major impact on our knowledge of factors contributing to the gap in health status between blacks and whites.

The Association of Minority Health Professions Schools is also very supportive of the Minority Biomedical Research Support Programs (MBRS), and the Minority Access to Research Careers Program (MARC). Clearly these two important programs have made a substantial difference in improving the number of Blacks and other minorities in the biomedical sciences. Even though these programs have both been placed within the jurisdiction of the National Institute of General Medical Sciences, we believe that the distinct mission and purpose of each of these programs warrants continued distinct support.

Disease Control

A number of diseases and disorders including AIDS, cancer, heart disease, infant mortality and others have a disproportionately high impact on Blacks and other minorities. Mr. Chairman, the Centers for Disease Control has reached out to our Association to develop and implement a strategy, plan of action and Cooperative Agreement to deal with these important issues. Working with the CDC Director, Dr. James Mason, AMHPS began a modest Cooperative Agreement with the CDC last year to address several specific program items, mostly within the concern of several of the various agencies of the CDC. During the coming year we hope to continue to make progress toward a meaningful Cooperative Agreement that will have an impact on the health of minorities throughout this great nation.

We urge that your Subcommittee provide adequate support for CDC's activities, especially as it relates to minority health.

Mr. Chairman, and members of the Subcommittee we appreciate your support of federal programs supporting health professions training. We firmly believe you are making a sound investment that is yielding results.

Senator COCHRAN. Thank you, Dr. Leavell, for that information and for the insight that you bring to the importance of this funding account.

I am delighted that Secretary Sullivan has already expressed his concern to the Office of Management and Budget about some of the programs that are funded that you have described today. I am convinced that he is going to have influence and will bring that to bear in the future in connection with some of these programs.

I am also delighted to point out that he is coming to my State to deliver a commencement address at Jackson State University on May 13. We are flattered by his presence there, and we are really pleased.

It is interesting to note that the President is going to be in our State that day delivering a commencement address at Alcorn State University and then on to Mississippi State University. We are going to have a full dose of Washington. [Laughter.]

Dr. LEAVELL. It sounds like it, sir.

Senator COCHRAN. Bigwigs on that day in our State, but it is wonderful, and we are really looking forward to it.

I heard you say the title 3 program provides some funding. Is that the title 3 of the Higher Education Act?

Dr. LEAVELL. Yes, it is, sir; and specifically the graduate section 326. A limited number of our schools are participating in that, and we hope that program continues to expand. If additional schools come in, then additional resources would come with them, so we do not dilute out the quality of the program.

Senator COCHRAN. I understand your concerns. I can remember offering on the floor of the Senate soon after I got to the Senate an amendment that added $35 million to that account when Senator Schmitt from New Mexico was the chairman of this subcommittee. I was not a member of this subcommittee at that time, but that amendment was agreed to on the floor, and it led to an increase in the actual appropriations that year beyond that which had been recommended by the full Committee on Appropriations.

Dr. LEAVELL. Senator, I can assure you, as one of the presidents of a college that is receiving those funds, what a beneficial nature the funds have been. It has permitted us as the legislation has intended to support our infrastructure and the academic programs in a way that our budget would not have previously permitted us to do.

Senator COCHRAN. Those are important funds to many colleges and universities in my State of Mississippi. I remember when Dr. Sullivan was at Morehouse, he and other college presidents in historically black institutions of higher learning came to Washington for a meeting, and I met with them to talk about that program.

I am convinced that President Bush is going to support that program, too. He has requested emphasis be placed on that program and an increase in funding be granted under that program.

Dr. LEAVELL. We are pleased to hear that, sir.

Senator COCHRAN. So that is encouraging, is it not?

Dr. LEAVELL. Yes, sir.

Senator COCHRAN. Thank you again for being here.

Dr. LEAVELL. Thank you. We appreciate it.

Senator **Cochran**. I offer my word of welcome to those who have come with you today. We appreciate your presence at our hearing.

Dr. **Leavell**. Thanks again, Senator.

SUBCOMMITTEE RECESS

Senator **Cochran**. Thank you very much. The subcommittee will stand in recess until 9:30 a.m., Friday, May 5, when we will meet in SD–192 to continue our public witness hearings on the administration's fiscal year 1990 budget request.

[Whereupon, at 12:15 p.m., Thursday, May 4, the hearing was recessed, to reconvene at 9:30 a.m., Friday, May 5.]

DEPARTMENTS OF LABOR, HEALTH AND HUMAN SERVICES, AND EDUCATION AND RELATED AGENCIES APPROPRIATIONS FOR FISCAL YEAR 1990

FRIDAY, MAY 5, 1989

U.S. SENATE,
SUBCOMMITTEE OF THE COMMITTEE ON APPROPRIATIONS,
Washington, DC.

The subcommittee met at 9:39 a.m., in room SD–192, Dirksen Senate Office Building, Hon. Tom Harkin (chairman) presiding.

Present: Senator Harkin.

NONDEPARTMENTAL WITNESSES

Senator HARKIN. Good morning. The subcommittee will come to order.

This morning we continue with the third of 6 days of public witness testimony focusing on programs funded by the Subcommittee on Labor, Health and Human Services and Education and the 17 related agencies. During the several sessions the subcommittee will hear testimony from approximately 150 witnesses.

It is a matter of regret to tell all members of the subcommittee that we have had to limit the number of witnesses we are able to hear this year. All of you have been very understanding about our time constraints and I do want to assure you that witnesses who have their testimony to us in writing by May 15 will have that testimony in the record.

We have this red light/green light system that we are using right now to try to limit witnesses to the appropriate 3 minutes. I ask you to summarize your remarks as succinctly as possible so that each witness will have an equal and fair opportunity to be heard.

As many of you know last night the Senate passed the 1990 budget resolution. For programs in this subcommittee it includes, as best that we can tell, just a little over a 4.1-percent increase for new spending.

I notice that many of you who are here today are here to support the full professional judgment budget of NIH, or $8.4 billion. This is a 17.5-percent increase over last year. Even the President's request of a 5.3-percent increase over last year will be a challenge for us to meet, let alone the 17.5 percent, although we will do the best we can.

STATEMENT OF PATTY DUKE, NATIONAL ALLIANCE FOR THE MENTALLY ILL

Senator HARKIN. This morning, we would like to welcome as our first witness, Miss Patty Duke, obviously a very nationally known performer in the performing arts, representing the National Alliance for the Mentally Ill. Miss Duke, welcome to the subcommittee. We are pleased and honored to have you here and we look forward to your testimony and we are pleased to have your family with us, too. It is always refreshing to see kids here. It makes us realize what we are really doing here.

Ms. DUKE. He has the same effect on us. Thank you, Mr. Chairman.

Mr. Chairman, on behalf of the National Alliance for the Mentally Ill, a network of 70,000 families whose lives are directly affected by a mentally ill relative, we thank you for this opportunity to share our views with you today.

I would like to bring to the attention of the subcommittee the 400,000 signatures gathered by NAMI in support of a $502 million research appropriation for the National Institute of Mental Health.

The signatures were gathered in the dead of winter by families—families compelled by the conviction that research is our best hope to relieve the $40 billion burden of direct care and treatment of mental illnesses and the $50 billion in indirect cost such as lost labor imposed on the Nation as well as the victims of mental illness themselves and their families. These signatures, bound together into 40 volumes of a Book of Hope, serve as visual reminders of the broad public endorsement of a stronger Federal role in mental illness research.

It is just such research, Mr. Chairman, which allows me to be here today. In 1982 I was diagnosed as manic depressive. My mental illness is a genetic, chemical imbalance of the brain. It manifests itself in dramatic mood swings from states of euphoria, or agitated, out-of-control highs to disabling, often suicidal lows.

From the onset of the symptoms of this illness in my late teens, until proper diagnosis and treatment at the age of 35, I rode the wild roller-coaster. During manias I squandered ever cent I had earned. I became unemployable for a time due to bizarre behavior. During a particularly extreme episode I even married someone I did not know. It lasted 13 days.

When the pendulum swung, I was nonfunctional during months and months of deep depression. There were costly hospitalizations for phantom physical ailments never diagnosed. There was abuse of alcohol in an effort to escape and there were suicide attempts. The stamina of my children to withstand the chaos and their abiding love probably kept me alive until we were all able to benefit from the expertise of a fine psychiatrist and the tool born of research that was put in his hand—lithium.

As a result, 7 years later I come before you today a healthy, productive citizen who owes a great deal to the research into my illness and for my well-being. The sum of $502 million is obviously a great deal of money, but according to NIMH figures, in each of the years between 1979 and 1984, $500 million was saved with the advent of lithium. In light of that fact, we believe that a $502 million expenditure on schizophrenic research and research into major depressive disorders is cost effective.

PREPARED STATEMENT

Again, on behalf of the 400,000 people who signed the Book of Hope and the millions who suffer from mental illness, their families and mine, thank you Mr. Chairman and distinguished members of the subcommittee for your sincere consideration of our petition.

Thank you.

[The statement follows:]

STATEMENT OF PATTY DUKE

On behalf of the National Alliance for the Mentally Ill (NAMI), a national network of 70,000 families whose lives have been directly affected by a mentally ill relative, I would like to thank you for the opportunity to share our views with you this afternoon.

The NAMI Petitions

Before beginning my testimony, however, I would ask the Subcommittee's permission to present the 400,000 signatures gathered by NAMI in support of a $502 million research appropriation for the National Institute of Mental Health (NIMH). These signatures were gathered by our families (including aging parents, consumers, spouses, and siblings) over the course of this past winter.

We hope that you will reflect on the enormous effort that went into the NAMI petition drive. It was inspired by the conviction that research is our best hope to relieve the $40 billion burden of direct care and treatment for mental illnesses and the $50 billion extra in indirect costs (e.g., lost labor) imposed upon this nation -- tremendous financial burdens borne by the victims of mental illnesses, their families and society as a whole. That is why we have bound the petitions into 40 volumes of a Book of Hope. We want these petitions to serve as visual reminders of the broad public endorsement for a stronger Federal role in mental illness research.

Research Opportunities

NAMI is asking your Subcommittee to support a basic brain research agenda by appropriating $502 million for non-AIDS related research, research training, and research management and support by the National Institute of Mental Health (NIMH) during the next fiscal year. The amount requested represents NIMH's Professional Judgment Budget. In addition to the 400,000 people from urban and rural communities in every state who signed the petition, it has also been endorsed by our colleagues in the Mental Health Liaison Group, the Citizens Consortium for Disabilities, and the 13 national associations which make up the MIRACLE coalition*.

Approximately 90% of all research on mental illness in America is financed by the appropriation to NIMH that you are considering. Unlike other health issues, mental illness has no significant private sector constituency committed to research, so that progress is dependent upon the responsiveness of the Federal Government.

With 2.5 million Americans suffering from schizophrenia and over 14 million diagnosed as having an affective disorder, with a third of our nation's homeless suffering from mental illness, with psychiatric patients utilizing the largest block of hospital beds in this country, and with the costs of care in hospitals and the community exploding, we desperately need solutions proportionate to the problem.

Fortunately solutions are on the horizon. Within the last year, research scientists have identified genetic markers for forms of both manic depression and schizophrenia. A new medication to help control a fraction of various resistant forms of schizophrenia is about to appear on the market and others are under development. New technologies like magnetic resonance imaging permit us exciting ways to examine the brain and explore the mysteries of the nervous system. And each development is like a snowball rolling down a hill--the original discovery becomes the nucleus for further expansions in knowledge, which accumulates with accelerating speed.

An investment in research would be a judicious use of limited public dollars. A single discovery or development of a new treatment could literally pay the entire cost of the requested appropriation, while significantly improving the lives of millions of our fellow citizens. For example, in the past ten years, an estimated $12 billion was saved in direct and indirect costs as a result of the advent of just one drug, lithium, used in the treatment of manic depressive illness.

For rural Americans, new medicines to control the symptoms of mental illness may make it possible for them to remain in their communities, instead of relocating to major urban centers where intensive psychiatric care is available. And the research investment we seek may also help combat substance abuse, since we know that comorbidity among mentally ill persons runs as high as 50 to 60%. People with mental illnesses who now self-medicate with illicit drugs and alcohol may find relief for their dual diagnoses through improved treatments for their underlying brain disorder.

The $502 million we are seeking is approximately $141 million more than the President's request, which seems startling at first glance. But it is important to keep in mind that the President's request is

$28.6 million below what is necessary just to keep current research activities funded. And we still have a lot of catching up to do if we are to redress past neglect in the research arena.

Services Research Needs Support

While biomedical research is clearly a major priority with NAMI, there are other budgetary items of importance to us. And services research is one of those of critical significance. After decades of experience, the reality is that we still do not know precisely what works and what does not, and under what conditions certain treatment or delivery strategies are most effective.

The time has come to fortify NIMH's efforts to upgrade the research component in the services arena, to assure outcomes that will increase our knowledge base. We believe that services research should be funded at both the clinical and system levels.

Homelessness

Since an estimated one third of all homeless persons have serious mental illnesses, NAMI views PL 100-628, the Stewart B. McKinney Homeless Assistance Amendments, as vital to any national strategy to eliminate the scourge of homelessness from our midst. Shelter itself is not enough. For the victims of brain disease, treatment must be made available as well.

We support full funding for all McKinney Act programs, but join with our colleagues in the Mental Health Liaison Group in calling for an increase in the state grant program beyond its currently authorized ceiling. We recommend an FY 1990 appropriation of $100 million for the block grant to substantially enhance our capacity to meet the crisis.

State Planning Grants

We support reauthorization of the state planning grants under PL 99-660 (Comprehensive Planning for Mentally Ill Individuals Act) and urge the Subcommittee to "fence" $10 million for this purpose, contingent upon the reauthorization of the program, as contained in the Senate technical amendments to the Omnibus Drug Bill.

Neglected Populations

We urge that greater attention be placed upon the unique needs of children and adolescents--including youngsters in transition to adulthood--elderly persons, forensic patients, ethnic minorities, persons dually diagnosed in conjunction with substance abuse, and mentally ill individuals residing in rural areas. We seek a system of care which meets their needs along with all others suffering from serious mental illnesses. We sometimes hear talk about "treatment resistant clients," but in our judgment, the problem is more often "client resistant systems." Equity and justice demand a response to the suffering of those neglected by the current service structures.

We could, Mr. Chairman, continue through the litany of vital activities of the National Institute of Mental Health, including the particularly valuable CSP and CASSP programs, but I am sure you know that NAMI values the full range of the Institute's mission and supports adequate funding for it to continue its work.

On behalf of the 400,000 people who signed the NAMI petition and on behalf of the millions who suffer from mental illnesses, their families and friends, thank you.

(*The members of MIRACLE are: American Academy of Child and Adolescent Psychiatry, American College of Neuropsychopharmacology, American Nurses Association, American Psychiatric Association, American Psychological Association, National Alliance for the Mentally Ill, National Association of Social Workers, National Association of State Mental Health Program Directors, National Council of Community Mental Health Centers, National Depressive and Manic Depressive Association, National Federation of Societies for Clinical Social Work, National Mental Health Association, and National Mental Health Consumers Association.)

MENTAL ILLNESS

Senator **Harkin**. Thank you very much. That is very poignant testimony. It is not often that people will publicly, in front of the world, talk about mental illness. They may talk about somebody else's but they will not talk about theirs.

Ms. **Duke**. It is not quite what I had in mind when I wanted to come to Washington and be a star.

Senator **Harkin**. I understand. It is always interesting, though. It is just something we have really got to overcome. People will talk about their illnesses. If they have got cancer they will talk to you about it. Whatever it is they will talk about it.

But mental illness still has that kind of cloak of, something is wrong with you—it is not genetic, it is something that maybe you did wrong, not something that is an illness or disease. But you just cannot do anything about it unless you have the proper treatment.

Hopefully, more and more people will take your lead and will come forward like this and talk about it. I think the more you bring it out into the light of day and the more we understand mental illness, the more we can get these research dollars that we need to attack the problem.

I mean, obviously I have known of you since—I do not want to say how many years, maybe 25 or more years—and I was not aware of that, obviously and I think a lot of times you read about people that are well-known personalities, whether it is in the performing arts, maybe sometimes in government, whatever it might be and maybe they do things that you think well, maybe are not in the normal constraint and perhaps a lot of times people say, well, that is just what people like that do, you know. Then they hear you tell about what has happened in your own life. It is just a very, very poignant thing.

Ms. DUKE. Thank you, Senator. The truly extraordinary thing to me is that for my illness, at least, there is treatment and you do get well. Of course, having been there you do not ever want anyone else to go there again and hence our participation in asking for these research dollars.

Senator HARKIN. Well, all I can tell you is that we will do our best.

Ms. DUKE. I know.

Senator HARKIN. We have these budget constraints. You know, we talk about national security. How about all the lost productivity of people out there that need this kind of help? We need a new definition of national security.

Ms. DUKE. I will buy that.

Senator HARKIN. There is economic security and health security, too. Let me think about this. This fiscal year we have $394 million. Next year, what you are asking for—what the professional budget asks for is $502 million. That is less than the cost of one B-2 bomber.

Ms. DUKE. I am glad you brought it up.

[Applause.]

Senator HARKIN. Not the whole fleet, just one. Well, as I have often said, the budget deficit that we are trying to reduce is not just a matter of mathematics, it is a matter of priorities. It is where we want to put our priorities. Well, with your help and many, many others perhaps we can change some of these priorities. How many signatures have you got there?

Ms. DUKE. 400,000, gathered by aging parents and siblings and spouses in the winter, not in southern California alone. It is impressive. It is really impressive. Nothing professional went into that.

Senator HARKIN. I am going to—thank you. I will not even recess. I am going to go back there. I want to get a picture taken with you—not just have a picture taken, because I tell people if you really want to make an impact, this is the way to make an impact and I think this is a classic case of citizens putting their name on the line for something they believe very strongly in. I know your time constraints. I know you have to leave and I do not want to keep you here for 2 more hours. I did not know that is what all that was out there.

Ms. DUKE. You just thought that was your paperwork for today.

Senator HARKIN. That is right. That is what Mike gave me for the weekend. Thank you very much.

Ms. DUKE. Thank you again.

[Pause.]

Senator HARKIN. Where did you get these? Nationwide?

Ms. DUKE. Nationwide. If I may, unofficially. One of the things that NAMI has been talking about now that is so important is that many people who gather these signatures are parents who are caring for their mentally ill children who are my age and older.

These parents—it is in the nature of things, they are 70, 75 and they are concerned about where is the care going to come from once they are gone?

Ms. **Duke**. This makes me feel good.

Senator **Harkin**. You are right about what is going to happen, the other part also is I have known families with children who are handicapped—mentally handicapped and physically handicapped and they have to take care of them. They cannot just have a babysitter come in and take care of them so they are there 24 hours a day, 7 days a week. They cannot even go out and eat dinner. They cannot go on a vacation.

Ms. **Duke**. The stress is more than any of us can imagine, I am sure.

Senator **Harkin**. I know of families who have split up because of the stress. They did not have anyone to come in and help. So when you think of day care, there is a real need for respite care for parents of handicapped children. I appreciate it. It is wonderful. Thanks. Let us hear it for a great witness.

[Applause.]

STATEMENT OF DR. ALICE HUANG, PRESIDENT, AMERICAN SOCIETY FOR MICROBIOLOGY

Senator **Harkin**. Next, let us call Dr. Alice Huang, president of the American Society for Microbiology. Dr. Huang, please proceed.

Dr. **Huang**. Thank you, Mr. Chairman. My name is Alice Huang. I am the president of the American Society for Microbiology. I am also a professor at Harvard Medical School and a trustee of the University of Massachusetts.

I sincerely believe that the structure of our biological scientific enterprise in institutions of higher learning is being eroded as a result of gradual and continued underfunding by the Federal Government. That is why I am here under the auspices of the ASM, which is the largest single biological society in the world with an active membership of over 34,000.

We are greatly concerned by the minimal increase proposed for NIH by the President. For 1990 the proposed budget will reduce the number of new and competing research grants by 25 percent below the fiscal year 1988 level and would fund 845 fewer research trainees than in fiscal 1988.

The ASM supports the recommendation of the ad hoc group for medical research funding, which proposes a budget of $8.4 billion for the NIH. In fiscal 1990, nearly two-thirds of the increase accounts for inflation and the need to be able to fund approved grants at the amounts actually recommended by initial review groups.

We commend the increase of 20 percent for AIDS research. However, it is important to note that all of the methods used to study AIDS and most of our insights into this infectious disease are the consequence of research that was not—let me repeat, that was not—specifically directed toward AIDS but which was conceived of as being fundamental, basic research. Many of us, including Dr. Fauci of NIH, are convinced that the information still needed to effectively treat AIDS will also be the consequence of such fundamental efforts.

The congressional mandate in the appropriations bill should be broadened to allow the use of AIDS funds to support fundamental projects that are judged to be relevant. The battle against AIDS has not lessened the need to continue investigations on other infectious diseases. The ability of NIAID to deal with these problems is being hamstrung, because outside of the area of AIDS research budgetary increases for that institute have been below inflation and below the average non AIDS budget increases of NIH as a whole.

The last and perhaps most crucial point which I would like to convey is the disastrous situation occurring now, in 1989. Outstanding young career scientists with approved grants in the top 30 percentile are going unfunded and training programs are suffering at the best institutions. The lifeblood of our scientific efforts depends on the continuing influx of bright young people.

PREPARED STATEMENT

There should be a modest increase in the number of training positions. We support the ad hoc group for medical research funding in their proposal for $315 million for a total of 11,800 trainees in fiscal 1990.

On behalf of the ASM I wish to thank the chairman for the opportunity to comment on the NIH budget.

[The statement follows:]

STATEMENT OF DR. ALICE S. HUANG

My name is Alice Huang and I am President of the American Society for Microbiology (ASM). I am also Professor of Microbiology and Molecular Genetics at Harvard Medical School and Childrens' Hospital. The ASM is the largest single biological life science society in the world with an active membership of over 34,000. I wish to thank the Chairman of the Senate Appropriations Subcommittee on Labor, Health and Human Services, Education and Related Agencies for the opportunity to express the views of the ASM on the fiscal year 1990 budget for the NIH.

Biomedical research not only serves to directly improve the health of our citizens as well as the rest of the world's peoples, but also to enhance the strength of our country in a competitive sense. Therefore, we are concerned by the minimal increase proposed in the President's FY 1990 NIH budget. Those of us who review applications to the NIH believe that numerous opportunities for progress and discoveries which could significantly reduce the cost of health care will be missed if the proposed budget is not increased. In FY 1989 the number of new and competing research project grants estimated to be funded is 14% below the number funded in FY 1988. The Administration's budget proposes to reduce the number of new and competing research project grants by 25% below the FY 1988 level. This is unconscionable. These reductions are occurring as increasing numbers of quality research ideas continue to go unfunded, demonstrating both the existence of additional scientific opportunities and the continued need for growth to take advantage of them.

The ASM supports the Ad Hoc Group for Medical Research Funding's proposed budget of $8.416 billion for the NIH in FY 1990. Nearly two-thirds of the requested increase represents the amount needed to account for inflation and to be able to fund approved grants at the amounts actually recommended by the initial review groups. The remainder of the requested increase represents a judicious assessment of research opportunities of which it is imperative to take advantage. For several years, it has been the policy of the NIH to fund grants at a level significantly below the levels recommended by the initial review groups in order to be able to fund the congressionally mandated number of grants. Continued funding of grants year after year at less than the recommended levels is deleterious to the ability of investigators to be able to successfully carry out the proposed and approved research. We encourage the Congress to provide adequate monies to provide full funding for research grants. The Ad Hoc recommendation restores funding of research project grants to the recommended levels and maintains some measure of growth in the system to provide support for new people and new ideas.

We strongly support the increase of 20% for funding NIH AIDS research. Conservative estimates envision a minimum of several million cases of what up to the present is an invariably lethal disease. Thus, development of methods for prevention and treatment is imperative. Knowledge of the biology of the human immunodeficiency viruses (HIV) and the pathogenesis of the disease, as well as possible ways to attack the problem, is already extensive. It is important to note that the methods used to study the problem and most of our insights into the mechanisms involved are the consequence of earlier and current research not specifically directed towards AIDS, but which was conceived of as being fundamental basic research in the areas of molecular biology and genetics, virology, bacteriology, mycology, and immunology. It seems certain that information still needed to effectively prevent and treat AIDS will also be the consequence of such fundamental efforts. NIAID Director Fauci has frequently stated his recognition of this and the desire to be able to use AIDS funds for this type of fundamental research. Yet the NIH feels constrained to use the AIDS funds only for research projects specifically targeted to AIDS under the terms of the Congressional mandate. The national research efforts against AIDS would be greatly enhanced if the Congressional mandate in the appropriations bill were broadened to allow the use of AIDS funds to support fundamental projects which in the view of Dr. Fauci and his staff have a likelihood of providing information of help in the battle. We strongly encourage the Congress to take this action which would not require funds in addition to those already proposed by the President for FY 1990, but which might add greatly to the useful information generated by the AIDS budget. The ASM recommends against consolidating authority for all AIDS funding in the Office of the Assistant Secretary for Health because funding for AIDS research decisions should remain at the institute level.

The battle against AIDS has not lessened the need to respond to other infectious diseases. Influenza is still a major killer. Vaccines need improvement, we have no antiviral therapy available for Type B influenza, and no vaccines against herpes simplex, chicken pox, cytomegalovirus or Epstein Barr virus. A newly discovered herpes virus, HHV6, has been implicated as the possible cause of chronic fatigue syndrome and possibly some human cancers. There is no vaccine or chemotherapy for human papillomavirus, which may be the cause of carcinoma of the cervix. Although we now have an effective vaccine for hepatitis B, we do not have effective chemotherapy for those already chronically infected. We are still trying to develop effective vaccines for hepatitis A and non-A non-B hepatitis. The same is true for the many agents which constitute the sexually transmitted diseases. We also need to attend to newly recognized agents such as that of Lyme disease. Even diseases which were thought to be under control, such as measles and tuberculosis, are undergoing a resurgence in frequency. Our best hope in most of these diseases is to apply our recently acquired knowledge concerning the fundamental mechanisms of pathogenesis. To understand the fundamental basis of a disease is to be able to target specific methods of prevention and cure. Yet much remains to be done at the basic levels of bacteriology, virology and the immune response.

The ability of the National Institute of Allergy and Infectious Diseases (NIAID) to deal with these problems is hamstrung, because, outside of the area of AIDS research, budgetary increases for the Institute have been below inflation and below the average non-AIDS budget increases of the NIH as a whole. This neglect of major areas of health concern represents a dereliction of responsibility on the part of the Administration. Infectious diseases have always been major causes of human mortality. We are in a position to make further gains at relatively low cost and encourage Congress to provide the necessary support to the full extent that can be effectively used.

The life blood of scientific efforts is a continual influx of bright young people into research to replace and add to those leaving. A current crisis exists in the area of training those replacements. A career in biomedical research is currently perceived in a less favorable light by young people; an attitude undoubtedly fueled by the perception of the difficulty in obtaining research support. This negative factor is exacerbated by the problems with support of current trainees. For FY 1989, Congress thought that it was funding over 11,000 training slots. Because of a decision by the NIH administration to increase stipends after the FY 1989 appropriations bill was passed, the number of training positions that could be funded was greatly reduced and the difficulties have been magnified by uneven administration among the Institutes to deal with the shortfall. The ASM supports the stipend increase, but believes that it needs approval and support from the Congress and even administration across the NIH. We support the modest increase in the number of training slots recommended by the Ad Hoc Group for Medical Research Funding. The Ad Hoc Group proposes a total of $315 million for research training to increase the number of trainees to the level of 11,800 in FY 1990.

We recommend an additional $3.5 million for the Minority Access to Research Centers (MARC) program in FY 1990 because of intense student interest and an overabundance of eligible applications which cannot be funded because of budgetary restraints. The NIH intramural program is one of the most prestigious, successful and essential research organizations in the world, and we urge administrative and legislative proposals to raise the pay cap for senior government scientists to prevent the further loss of top level scientists from the NIH intramural program. We recommend restoration of funding for Biomedical Research Support Grants at the FY 1989 level ($55.4 million) because the program represents an important source for stabilizing research support. We also support the Ad Hoc Group's request for funds for NIH intramural research and renovation of the nation's scientific physical plant. We must address space and equipment needs for AIDS research and improvement of animal facilities.

Senator HARKIN. Dr. Huang, thank you. Now, you are asking for 11——

Dr. HUANG. 11,800 trainee positions, yes.

Senator HARKIN. There are now 10,206, I understand. Is that right?

Dr. HUANG. Yes; although as you know the Congress, for 1989 thought that it was funding 11,000 trainee positions and that got cut quite seriously. In one of our training grounds we suffered a 73-percent cut that has generated tremendous instability.

Senator HARKIN. What was that in?

Dr. HUANG. That was our training ground for the M.D. Ph.D students, the health sciences training program; medical science, MSTP, medical sciences training program.

Senator HARKIN. We will do the best we can, Dr. Huang.

Dr. HUANG. Thank you so much.

Senator HARKIN. Thank you very much for being here.

STATEMENT OF HON. JOHN MELCHER, ON BEHALF OF THE SOCIETY FOR ANIMAL PROTECTION LEGISLATION AND THE HUMANE SOCIETY FOR THE UNITED STATES

Senator HARKIN. The next witness is the Honorable John Melcher. Gosh, John I did not see you there. How are you? Good to see you.

Senator MELCHER. Good to see you. Thank you for allowing me to testify this morning.

Senator HARKIN. We are glad you are here. You know, we heard from Miss Jane Goodall yesterday.

Senator MELCHER. Yes; I understand that.

Senator HARKIN. Mrs. Christine Stevens was with her.

Senator MELCHER. Some of my testimony will be repetitious so I will skim right through it.

Senator HARKIN. It is good to see you again. Nice to have you here.

Senator MELCHER. I very much appreciate this opportunity to address our concerns and I am testifying on behalf of the Society for Animal Protection Legislation and the Humane Society of the United States.

Some of the procedures and responsibilities of the National Institutes of Health need to be looked at rather carefully. I first want to comment on the chimpanzees in the wild as endangered. As we know the populations in the wild will be listed as endangered by the U.S. Fish and Wildlife Service. It is a very important step. Public Law 100-436, section 218, prohibits funding by NIH of research involving wild-caught chimpanzees. This should be, I believe, recognized, enforced right now and for the future.

I think the question is whether or not the NIH adheres to this as of right now for this current year. I would ask the subcommittee to look into that matter and make sure that it is done that way. There is an essential element in man's relationship to animals that is very natural. Treat them with respect and kindness.

While there are some people who would never agree to have any animal used for food nor have any animal used for medical research, I personally am not of that belief. But I do respect animals and because of that respect I zealously advocate treating them humanely, with kindness, within the parameters of man's animal stewardship.

Getting to the real meat of my testimony, right now, Mr. Chairman, the regulations to promulgate the 1985 amendments to the Animal Welfare Act are at the critical point of having been published in the Federal Register for comment. Before these are finalized it is essential that the National Institutes of Health take a public course that supports the intent of Congress in the passage of the amendments in 1985.

As you know, Mr. Chairman, those amendments were included in the 1985 farm bill and you are in the unique position of not only being one of the senior members of the authorizing committee, you are also the subcommittee chairman of the Appropriations Committee dealing with NIH and that unique position I suspect places both on you a responsibility and an opportunity to be of particular value now, as these regulations are commented on before they are finalized by the AFS and the Department of Agriculture.

The regulations have some important elements. All laboratory animals are to be taken care of to minimize the pain and stress involved in the research that is undertaken using these animals. In addition, they are to have adequate cleanliness and husbandry, maintained nutritionally sound, provided comfortable space and exercise and in the case of primates provide for their psychological well-being. All this is spelled out in clarity in the statute itself, in the amendments themselves.

The rhubarb over finalizing these regulations has been unduly long and unfortunately has had two negative aspects to it. One is that the Office of Management and Budget seems to think they play an important role in the clearing of regulations which are primarily the responsibility of the Department of Agriculture.

Second, there has been a lack of public discourse from NIH and I find that hard to understand. I think the public throughout the country believes that if they are using laboratory animals, a strong advocate for their care and attention should be the National Institutes of Health. I see no reason why the NIH is not out there publicly saying these regulations should reflect the intent of Congress, which is pretty clear in the amendments that were adopted in 1985.

Because all the requirements that are entailed in those amendments are reasonable, the Department of Agriculture has been buffeted around by different groups and has not had strong support by NIH.

OMB says they felt it was necessary to assess the cost. Well, the costs, hardly any of them could be Federal. They are almost all private, and the State institution costs that would be involved, because that is where the work is done—there are 1,300 medical research institutions, both private and public and approximately 5,000 animal shippers and suppliers, and the costs would be spread over a 3- or 4-year span.

The reason for that is that most of the costs entailed are capital improvements and, as we know, we cannot get capital improvements the first year. Sometimes it takes 2 or 3 years. The costs as projected by the Department of Agriculture are only an estimate, and it is something around $1 billion over those 2, 3, or 4 years.

There is some strong evidence that those costs, projected costs, are exaggerated. In any event, it is difficult to tell just what those total costs are. In a personal conversation I have had with a private institution they have indicated—that is a private company, an institution that engages in laboratory research. I was told that their current efforts to provide more space and better care for their primates in order to reflect the changes that are in the law are going on right now.

Well, that is a real hopeful sign to me. While I have not been able to personally document just how far-reaching those improvements have been, they indicate both a desire to make improvements even before the new regulations are finalized and, second, they are attempting to assure better research with the primates whose psychological well-being has been improved.

Now, the question here or the point I want to make right here is in any industry they constantly try to get better results. I do not care whether you are manufacturing nuts and bolts, whatever the industry is, they are always constantly trying to improve their process, so their results are better.

In this case, since the amendments were adopted and enacted into law in 1985 and during the time these proposed regulations have been discussed, a great number of the research institutions are trying to gear themselves to make the improvements now. So, whatever the projected cost is, some of that is being absorbed voluntarily at this point. It is not an excessive cost and even if it is exaggerated, most people I talk to tell me they have reason to believe very strongly that the $1 billion figure projected is an exaggerated figure.

The point I am trying to make is capital improvement is going to be over a period of time and will not hinder or hamper medical research.

The point is that if they are going to have better care of animals, the results will be better in research. We know that. That is concrete. That is basic.

Anybody that has milked a cow understands that the cow gives more milk day in and day out if the cow is not subject to stress while it is being confined and being taken care of and producing the milk.

It is the same thing in laboratory animals. If they are not subjected to stress, if they are in good shape, good health, the results are going to be much better.

There is one other thing that should bear on my testimony here this morning and bear on the responsibilities of all of us as a country and particularly on you, Mr. Chairman, in your capacity as subcommittee chairman for handling the purse strings for NIH, and that is NIH's alternative plan.

It is very desirable to substitute nonanimal models whenever that is possible, and the law requires it. We have found that in trying to find out how this is working out that there ought to be a definite procedure of requests for applications for developing nonanimal model research grants.

No one knows at this time how many of these types of grants have been awarded among the 14 institutes of NIH and, therefore, no one can ascertain how much research is accomplished without the necessity of using animals.

If the results can be obtained without using animals, obviously there is no pain or stress to animals and very likely the costs are reduced.

There are some pertinent facts I have included in my testimony dealing with Public Law 99-159, section 4 of the 1985 NIH authorization.

The real point is we believe Congress should direct NIH to have the alternate plans be made a request for applications of the biological models and materials research section, and this will put the plan under the direction of a section already substantially concerned with alternatives and centralizing the implementation of the plan will enable Congress to determine the extent of NIH's compliance.

We are also concerned that the alternative plan is currently in a nonfunded program announcement. Like all program announcements, the alternatives plan is intended to simply announce that grant proposals for alternatives research may be considered. There is no guarantee of alternative research program.

As a result, we urge that the subcommittee appropriate sufficient funds for this plan as a line item in the BMMR budget so that the alternatives research will be a viable research area.

PREPARED STATEMENT

Time and money as well as human health are also considerations in the need to support funding of alternatives. In short, since we know that the Office of Technology report has indicated that a battery of short-term tests have achieved a level of accuracy in the 80- to 90-percent range, and that is a high level of accuracy, we believe that a greater emphasis on alternatives is needed.

Thank you very much, Mr. Chairman. I would be glad to answer any questions.

[The statement follows:]

STATEMENT OF HON. JOHN MELCHER

I appreciate this opportunity to address our concerns about some of the procedures and responsibilities of the National Institutes of Health. I first want to comment on chimpanzees in the wild as endangered.

Chimpanzee populations in the wild will be listed as endangered by the United States Fish and Wildlife Service. This important step will bring the U.S. law in line with 99 other countries that adhere to the Convention on International Trade in Endangered Species, which prohibits commercial trade in chimpanzees.

Public Law 100-436, Section 218, prohibiting NIH funding of research involving wild-caught chimpanzees, should be recognized as being in force for 1989 and thereafter. The Subcommittee should make sure that NIH adheres to this.

There is an essential element of mans' relationship to animals that is natural: treat them with respect and kindness.

While there are some people who would never agree to have any animal used for food nor have any animal used for medical research, I personally am not of that belief. But, I do respect animals and, because of that respect, I zealously advocate treating them humanely with kindness within the parameters of mans' animal stewardship.

The regulations to promulgate the 1985 amendments to the Animal Welfare Act are at the critical point of having been published in the Federal Register for comment. Before these are finalized it is essential that the National Institutes of Health take a public course that supports the intent of Congress in passage of the amendments in 1985.

These are the important elements: All laboratory animals are to be taken care of with adequate cleanliness and husbandry, maintained nutritionally sound, provided adequate comfortable space and exercise, and in the case of primates provide for their psychological well being. In addition, the law requires NIH whenever possible, to call for the use of non-animal models to replace live animals used in medical research.

All of these requirements are reasonable. The Department of Agriculture regulations in some areas need to be strengthened. The size of cages are for some species too small for comfort or exercise. What is important for NIH is a positive practical public comment contribution to the proposed regulations.

The projected cost as prepared by the Department of Agriculture to implement the changes in the law total approximately $1 Billion dollars for the more than 1300 medical research institutions, both private and public, and approximately 5,000 animal suppliers, shippers and zoos spread over a two to three year span. My belief is that with so many facilities affected by the regulations, this figure may be credible. However, since laboratories and other facilities would need to undertake capital improvements and modernization to keep pace anyway, the federal government may only have to pick up modest amounts, if any, of this sum.

Since most of the cost is capital improvements, NIH should from their experience, comment specifically on workable regulations that spell out the time frame for the capital improvements to be accomplished.

In a personal conversation I had with a private institution engaged in laboratory research, I was told of their current efforts to provide more space and better care for their primates in order to assure better results in their laboratory research. This is a hopeful sign, for while I have not been able to personally document just how far-reaching those improvements have been, they indicate both a desire to make improvements even before new regulations are finalized and secondly, they are attempting to assure better research with the primates whose psychological well-being has been improved.

NIH'S ALTERNATIVE PLAN

While animals are widely used in a host of experiments it is desirable to substitute non-animal models wherever possible. This process is not new or strange to NIH which has been dividing among its 14 different institutes some Program Announcements for development of non-animal model research grants. I urge, Mr. Chairman, that NIH follow a definite procedure of Request for Applications for developing non-animal model research grants. No one knows at this time how many of these types of grants have been awarded among the 14 Institutes of NIH and therefore no one can ascertain how much research is accomplished without the necessity of using animals.

If the results can be obtained without using animals, obviously there is no pain to animals, and very likely the costs are reduced.

Let me give you the pertinent facts on this.

In Public Law 99-158, Section 4, of the 1985 NIH authorization, Congress directed NIH to establish a research plan "into methods of biomedical research and experimentation which do not require the use of animals; which reduce the number of animals used in such research; or which produce less pain and distress in such animals than methods currently in use..." Congress has recognized that these alternative methods of research are not only more humane but could also "provide more accurate research results and reduce the cost of research..."

Unfortunately, however, NIH is not meeting this congressional mandate. There are two reasons for this:

First, the plan has been instituted simply as an NIH-wide program announcement. There is no centralized control over the program nor is there an administrative unit within NIH responsible for implementation of the plan. Hence, information about NIH compliance with the plan is virtually impossible to ascertain. The result is that NIH's traditional priorities of laboratory animal research take precedence over the intent of the plan to reduce animal based research and to further the advancement of science by utilizing alternatives.

The Trans NIH Coordinating Committee for Research Animal Resources (CCRAR), established in 1986 by NIH in response to a congressional mandate, noted that "while NIH spends considerable monies on projects that do not use animals, there is no focused program to develop non-animal models for research."

In light of this, we believe Congress should direct NIH to have the alternatives plan be made a Request For Applications (RFA) of the Biological Models and Materials Research Section (BMMR). This will put the plan under the direction of a section already substantially concerned with alternatives. Centralizing implementation of the plan will enable Congress to determine the extent of NIH's compliance or noncompliance with the congressional mandate and help direct improvements in the program.

We are also concerned that the alternatives plan is currently an unfunded program announcement. Like all program announcements, the alternatives plan is intended simply to announce that grant proposals for alternatives research may be considered. There is no guarantee of any alternatives research program. As a result we urge that the Subcommittee appropriate sufficient funds for this plan as a line item in the BMMR budget, so that alternatives research will be a viable research area for the scientific community.

Within NIH there are scientists, researchers and policy makers who are committed to the development of alternatives.

They know that "alternatives" are good science and that they hold great promise for human health advancements. Therefore we cannot underestimate the potential benefits of alternatives. Between 1901 and 1985, alternative methods made many of the key contributions to successful research efforts awarded Nobel prizes in physiology and medicine.

Time and money as well as human health are also considerations in the need to support funding of alternatives. A typical biomedical assay can take as long as two to three years while a short-term battery of in vitro or cell culture tests may produce results in as little as three to four months with minimal costs. The Office of Technology Assessment Report has indicated that a battery of short-term tests have achieved a level of accuracy in the 82-90% range. In short, a greater emphasis on alternatives is needed.

I will be happy to answer any questions you may have.

Senator HARKIN. Senator Melcher, thank you for your testimony. I cannot think of any individual who could speak with more authority and knowledge on this subject than a doctor of veterinary medicine who also served here as both a Congressman and as a Senator.

I know that you are the author of the legislation, the amendment that set up the psychological well-being amendment as we talked about. So, I appreciate your continuing and abiding interest in this. I brought it up with NIH on Monday.

Their own facilities do not meet the standards but they said that they have $23 million from previous appropriations they are spending to upgrade their facilities to meet the standards. They estimate that they will need an additional $25 million to complete that process.

I do not know if they told me how much longer it would take. I suppose if they got the money, they could do it. But I was surprised myself to learn that their facilities do not meet the standards, and I am not talking just about those that they contract with.

So, we will continue to look at this, and I ask you to always keep me informed.

Senator MELCHER. I would be glad to help in any way I can. I believe we are on the threshold of a more enlightened attitude toward animals that we use in research, and I applaud that not just from the angle of humaneness which we all have our responsibility to be concerned about, but also from the aspect of more successful laboratory animal research.

Senator **Harkin**. Thanks again. I appreciate your letting the first two go before you. It was kind of you.

Senator **Melcher**. I was delighted to do that. Thank you very much, Mr. Chairman.

Senator **Harkin**. Thank you, Senator Melcher.

STATEMENT OF NANCY R. BURNETT, NATIONAL HEALTH COUNCIL—VOLUNTARY HEALTH AGENCY, WASHINGTON, DC

Senator **Harkin**. Next we will have Nancy Burnett, National Health Council—Voluntary Health Agency.

Ms. Burnett, thank you very much for being here. Your testimony will be part of the record. Please proceed.

Ms. **Burnett**. Good morning, Mr. Chairman. I am Nancy Burnett, of Waldorf, MD, and for the past 15 years I have suffered from rheumatoid arthritis, a chronic and disabling disease. That is 15 years, 15 operations for joint repair and replacement, and more than 60,000 aspirin. Yes; I am counting.

Although a cure for arthritis has not yet been discovered, medical research—specifically research that could not have been accomplished successfully without the use of animals—has enabled me to appear before you today. Though I am here to appeal to you for heightened Federal medical research funding, I feel an obligation to use this opportunity as well to strongly advocate that the public's interest in scientific advancement cannot be adequately served without the continued humane use of animals in bona fide research.

There is no doubt in my mind that medical research offers us the best long-term approach to reducing the cost of illness and its treatment.

Not so very long ago I was unable to walk, tie my shoes, or even comb my hair. But medical research has now enabled me to hold a regular job, a well-paying position in a technical career, and I have some hope of putting back into the economy as much as I took while, shall we say, under repair.

For this, Mr. Chairman, I would personally like to thank you and the members of the various committees who have made the funding possible to provide that research which has provided me with this opportunity.

Today I am testifying on behalf of the medical research invested in America's health campaign of the Voluntary Health Agency members from the National Health Council. They initiated the "Invest in America's Health" campaign in 1987. Together these 36 voluntary agencies have devoted billions of dollars to finding treatments and cures for diseases and disorders afflicting more than 160 million Americans living in virtually every community.

The National Health Council and its voluntary health agencies applauds the work that has been done so far in research and in appropriations for that research, but we feel that more is needed.

Despite our own expanding investments, these organizations all firmly believe that America's pressing health needs and research opportunities awaiting our scientists demand a large-scale societal commitment best led by the Federal Government.

We are alarmed by signs of erosion in that leadership, signs such as the failure to explore many promising avenues for medical discovery with the vast majority of research proposals approved by Federal research centers going unfunded. Considerable shrinkage in our Nation's pool of scientific investigators, growing disinterest by students in pursuing research careers. The diminished ability of publicly supported research laboratories to maintain and modernize facilities and equipment, the increased success of foreign challengers in the international medical research marketplace where the United States has historically been dominant, and the continued disparity between our Nation's annual health care spending now exceeding $500 billion and Federal support of medical research, only about $8 billion yearly despite the tremendous potential of research for reducing overall expenditures. We are all counting this money.

In short, we call upon our Government to continue and expand upon its leadership responsibility for medical research. Specifically we would like to recommend approval of the following fiscal year 1990 appropriation levels. National Institutes of Health, $8.4 billion; research and research training at the Alcohol, Drug Abuse, and Mental Health Administration, $933 million; Centers for Disease Control, $1.4 billion and, recognizing it does not come under your jurisdiction, Mr. Chairman, medical research at the Veterans' Administration for $249 million.

These fundings levels would begin to provide adequate support for long-term needs-based, opportunity-driven national medical research effort.

They reflect a consensus of opinion not only among voluntary health organizations, but also within the research and academic communities.

PREPARED STATEMENT

On behalf of the National Health Council's Voluntary Health Agency members and as someone who has experienced first hand the extraordinary sacrifices that some of us make just to be ordinary, I urge your adoption of our recommendations as a wise investment in America's health and economic well-being. We are all counting on you.

Thank you for this opportunity.

I would be delighted to answer any questions you have.

[The statement follows:]

STATEMENT OF NANCY R. BURNETT

Good morning Mr. Chairman and members of the Subcommittee. I am Nancy Burnett of Waldorf, Maryland and for the past fifteen years I have suffered from rheumatoid arthritis, a chronic and disabling disease. That's 15 years, 15 operations for joint repair and replacement, and more than 60,000 aspirins -- yes, I'm counting.

Although a cure for arthritis has not yet been discovered, medical research -- specifically research that could not have been accomplished successfully without the use of animals -- has enabled me to appear before you today. Though I am here to appeal to you for heightened federal medical research funding, I feel an obligation to use this opportunity as well to strongly advocate that the public's interest in scientific advancement cannot be adequately served without the continued humane use of animals in bona fide research.

I appear before you not as an invalid, completely incapacitated by my disease and a burden to my family and country. I am here proudly as a productive member of society, who is reasonably functional, both physically and financially.

There is no doubt in my mind that medical research offers us the best long-term approach to reducing the cost of illness and its treatment. Not so very long ago, I was unable to walk, tie my shoelaces, or even comb my hair. But medical research has now enabled me to hold a regular job -- a well-paying position in a technical career -- and I have some hope of putting back into the economy as much as I took out while under repair.

Today, I am testifying on behalf of the "Medical Research: Invest in America's Health" campaign and am accompanied by Richard Nugent, Chairman of the campaign and Director of Governmental Affairs for the Epilepsy Foundation of America, and Joseph Isaacs, Vice President for Government Relations of the National Health Council.

The voluntary health agency members of the National Health Council initiated the "Invest in America's Health" campaign in 1987. These 36 groups are listed on the back of the cover page of our written testimony. Unfortunately, they have been cynically referred to by some as "Disease-of-the-Month" clubs. In an unprecedented demonstration of unity and collaboration, however, they've put aside their individual focuses for this campaign because of mutual concerns about the instability of overall federal medical research funding and its serious ramifications.

Together, these voluntary agencies have devoted billions of dollars to finding treatments and cures for diseases and disorders afflicting more than 160 million Americans living in virtually every community. Despite their own expanding investment, these organizations firmly believe that America's pressing health needs and the research opportunities awaiting our scientists demand a large-scale societal commitment best led by the Federal government. However, they are alarmed by signs of erosion in that leadership due to the inadequacy of support. These signs include:

- our failure to explore many promising avenues for medical discovery, with the vast majority of research proposals approved by federal research centers going unfunded;

- considerable shrinkage in our nation's pool of scientific investigators and growing disinterest by students in pursuing research careers;

- the diminished ability of publicly supported research laboratories to maintain and modernize their facilities and equipment;

- the increased success of foreign challengers in the international medical research marketplace, where the United States has historically been dominant; and

- the continued disparity between our nation's annual health care spending (now exceeding $500 billion) and Federal support of medical research (only about $8 billion yearly) despite the tremendous potential of research for reducing overall expenditures.

In short, we call upon our government to continue and expand upon its leadership responsibility for medical research. We are at a time when our medical knowledge is reaching heights never before imagined and our capacity to achieve lifesaving breakthroughs has never been greater. Without a heightened, long-term Federal commitment to medical research, many Americans will suffer or die from diseases and disorders whose cures will continue to elude us. Moreover, we'll be heading into the future ill-prepared to meet tomorrow's public health challenges or the increasingly intense research competition from abroad.

In this period of fiscal restraint and massive budget deficits, Americans can feel very proud that their nation's support of medical research has always paid handsome returns. This is the perfect time for our Federal policymakers to reestablish medical research as the high-level national priority it deserves to be. Specifically, we are requesting approval of the following Fiscal Year 1990 appropriation levels for the four Federal centers for medical research:

- the National Institutes of Health -- $8.416 billion;
- research and research training at the Alcohol, Drug Abuse, and Mental Health Administration -- $933 million;
- the Centers for Disease Control -- $1.479 billion; and
- medical research at the Veterans Administration -- $249 million.

These funding levels will begin to provide adequate support for a long-term, needs-based, opportunity-driven national medical research effort. They reflect a consensus of opinion among not only voluntary health organizations, but also the research and academic communities as expressed via coalitions of their national associations.

On behalf of the National Health Council's voluntary health agency members, and as someone who has experienced first-hand the extraordinary sacrifices that many of us must make just to be ordinary, I urge your adoption of our recommendations as a wise investment in America's health and economic well-being.

Senator **Harkin**. Ms. Burnett, thank you very much for your testimony. There is only one area that you asked that is really not in our jurisdiction, and that is the Veterans' Administration.

Ms. **Burnett**. Yes; we understand that.

Senator **Harkin**. You did mention it is not under our jurisdiction.

Just a point of clarification. I notice you said that this research cannot be adequately served without the continued humane use of animals in bona fide research.

Ms. **Burnett**. Yes, sir.

Senator **Harkin**. I am sure you heard Senator Melcher's testimony before. The question is not whether we will use animals. It is how we will use them. That is the only question. Obviously animals are going to be used in research. That is a legitimate and necessary means for conducting research. The question is just how will they be used and how will they be kept and treated. You mentioned humane use, and I am glad you did do that. I am glad you said that. Thank you very much for your testimony.

STATEMENT OF DR. HOWARD K. SCHACHMAN, UNIVERSITY OF CALIFORNIA, BERKELEY, PRESIDENT, FEDERATION OF AMERICAN SOCIETIES FOR EXPERIMENTAL BIOLOGY, WASHINGTON, DC

Senator **Harkin**. Next is Dr. Howard Schachman—I hope I got that right. I stand corrected if it is wrong—University of California at Berkeley, Federation of American Societies for Experimental Biology.

Dr. **Schachman**. You did very well, Mr. Chairman. It is Schachman.

Mr. Chairman, thank you very much for this opportunity to testify.

As you have already stated, I am a professor at the University of California in Berkeley, and I am also speaking today as president of the Federation of American Societies for Experimental Biology.

The written statement is deposited with the committee, so I can avoid wasting your time with going into details.

I wanted to make several major points. One was, of course, one that you have shown a great appreciation for in the past, along with your committee members, and that is the value of basic research.

Basic research, as you have already seen witness this morning, has done an enormous amount toward eliminating suffering. It has eliminated a lot of diseases, and it has enriched the lives of many people for periods in the future.

In addition, it is not recognized widely, but basic research is what led to the present American pioneer technology industry which came from NIH funding through the use of restriction enzymes and work on DNA and RNA. And without that kind of basic research of 10 or 20 years ago, you would not have been in the position that we are in today.

The next point I wanted to make is that in addition to the basic research, we have the problem of training, and what is of serious concern to us who are university professors and are responsible for recommending programs to you is the loss of traineeships in American universities at the present time.

You have already heard a little bit of that kind of discussion. Part of that is not your fault, obviously. The stipends were raised last year by NIH. They had to be raised. And when they were raised with constant dollars, you know the result. The result was we lost, as you have said a few moments ago, about 1,000 trainees.

We think it is very important that these traineeships be restored because 20 years from now we will feel the brunt of that if they are not restored.

The next problem is the problem of the number of grants. As a lot of you know, even with the budget increase as you pointed out in your discussions with Dr. Wyngaarden when he testified not long ago, the cost—the raise in the budget is hardly sufficient to counter the cost-of-living increase and, as a consequence, you are not going forward. You are going backward.

This was part of your rejoinder to Dr. Wyngaarden I noticed when I read the transcript of that, and I think it is very important that we recognize that the budget must go up sufficiently to make sure that we can make progress in the future.

The number of competing initiated grants each year has now gone down, as you know, from about 6,200 to 4,800. This leaves the young investigator at a terrific disadvantage. Therefore, it is very important that we try to get that number of grants back up and without jeopardizing the size of the individual grants themselves.

I am aware of the tremendous problems that you face with the deficit, and it is very easy for us to come in here and ask for the sky in the way of NIH budgets. But we think the request that has come forward to you of $8.4 billion and the corresponding increase for ADAMHA is a very reasonable one.

PREPARED STATEMENT

We hope that your committee will give serious thought to the problems that I have just outlined in the hope that these can be alleviated.

I appreciate your time and effort on our behalf. Thank you very much.

[The statement follows:]

STATEMENT OF DR. HOWARD K. SCHACHMAN

Mr. Chairman and Members of the Subcommittee: Thank you for this opportunity to testify on the fiscal 1990 budget for the National Institutes of Health and the Alcohol, Drug Abuse and Mental Health Administration.

I am Dr. Howard K. Schachman, Professor in the Department of Molecular Biology at the University of California, Berkeley. I also am President of the Federation of American Societies for Experimental Biology (FASEB) and am representing FASEB at today's hearing.

The Federation is a nonprofit organization whose purpose is the dissemination of new knowledge in the life sciences through its meetings, publications, and programs. The approximately 30,000 members of the seven federated societies conduct research programs in the biological and medical sciences in major research, educational and clinical centers throughout the United States. FASEB has counted 114 Nobel Laureates among its membership since it was founded in 1912.

FASEB deeply appreciates the support your Subcommittee has given to biomedical research over the years. This support has been crucial to the effort to increase scientific knowledge and to eradicate disease. In particular, we are grateful for the Subcommittee's willingness to continue a high level of assistance despite the difficult fiscal problems facing this country.

We recognize that the federal deficit continues to be a major factor in responding to the nation's health agenda. But we also recognize that even in an era of diminishing resources biomedical science must move ahead with its humanitarian work. Through the Ad Hoc Group for Medical Research Funding, our community has developed what we believe are reasonable recommendations.

Our proposal for the National Institutes of Health in fiscal 1990 is $8.416 billion. For the research programs of the Alcohol, Drug Abuse and Mental Health Administration, we recommend $933 million.

The last half century has produced major advances in medical research. The development of antibiotics in the 1940's, the discovery of the anti-polio vaccine, and the successful work on techniques such as organ transplantation are important milestones in our history. Also, let me point out that all of the major medical advances we depend on today were made possible by the use of research animals.

As we enter the 1990's, we find ourselves in the midst of the biotechnology revolution. Through this new science it may be possible to cure the many genetic diseases that have eluded scientists and plagued humanity down through the centuries. Biotechnology also is providing jobs and products that boost the nation's economy and give it an important advantage in the international marketplace.

The fact that we have made so much progress can be traced to the willingness of Congress and the American people to support scientific investments today in the hope they will yield results tomorrow. But despite our progress, we cannot stop now. We dare not even slow down.

The nation faces very difficult problems in areas such as AIDS, Alzheimer's, cancer, heart disease, drug addiction and mental illness. These and other afflictions will not yield to short-term solutions, but will require many more years of scientific investigation. Thus, a long-term commitment of support from both NIH and ADAMHA is needed.

The investigator-initiated research project grant will continue to be the cornerstone of our effort. These grants go to the scientists who come up with the most promising ideas for making research progress. Experience has shown the importance of funding many grants across the spectrum of disciplines because one never can be sure what areas of research will prove to be the most relevant in the long run.

Ultimately, the level of federal support will determine how quickly scientists are able to capitalize on the available research opportunities. But under the Administration budget request, the NIH appropriation, excluding support for AIDS and human genome research, would grow by only about 3 percent. Even when AIDS and genome research funds are added in, the Administration proposal provides only for a 5.3 percent increase over fiscal 1989. This is well below the level needed to maintain existing NIH programs at their present "current services" pace of activity.

On the other hand, we believe our recommendation of $8.416 billion for NIH will maintain the momentum of biomedical research progress. Although this amount is some 12 percent above the very low budget request, it is only about 5.7 percent above current services. Still it would allow for restoration of programs that the budget would cut or inadequately fund, and it also would allow for some modest growth.

Our recommendation would restore the number of NIH new and competing research project grants to earlier, more desirable levels. This is needed because the President's budget request proposes to reduce the grant level to only about 4,800 compared to the 6,200 provided in fiscal 1988. The Ad Hoc Group proposal would provide for fully funding one out of three approved research project grant applications in fiscal 1990.

Our proposal assumes 11,800 research training positions under the National Research Service Awards program. This would be a more realistic level for training which lost about 1,000 positions as the result of the unfunded stipend increase that was put into effect in the current fiscal year. Without adequate support for research training, we seriously undermine our efforts to even maintain, much less expand, the cadre of new research investigators who will be needed both to continue basic research programs and to initiate new programs in mapping the genome or pursuing AIDS retrovirology.

Our recommendation also assumes modest increases over fiscal 1989 for research career awards, the biomedical research support grants program and clinical trials. A separate request is made for construction.

For Alcohol, Drug Abuse and Mental Health research, we believe the $ million suggested would provide a far more realistic support level than $792 million proposed by the Administration.

We also recommend increases in ADAMHA research project grants, traini centers and research career awards, among other matters. There would be particular emphasis on schizophrenia and brain research while providing stabilizing amounts for drug abuse and alcoholism research programs.

Mr. Chairman and Subcommittee members, we recognize the difficult prob you face in choosing among the many worthy programs under your jurisdicti But we believe that biomedical research holds out so much hope for saving lengthening and improving life that it merits the continuation of the extraordinary support you have given it. We urge the adoption of our recommendations. Thank you and I will be pleased to answer any questions.

Senator **Harkin**. Doctor, thank you. Basically we have $706 million in this research program this year.

The 1990 budget from the administration calls for $657 million, and you are testifying on behalf of the professional budget of $933 million.

Why is there a cut in it this year? Does this include AIDS?

Dr. **Schachman**. Yes; that includes AIDS.

Senator **Harkin**. So, it does go up a little bit if you include AIDS.

Dr. **Schachman**. Our request would be about 5.3 percent above current services.

Senator **Harkin**. Thank you very much, Dr. Schachman. We appreciate your being here.

STATEMENT OF DR. FRANK BOWE, PROFESSOR, HOFSTRA UNIVERSITY, CHAIRPERSON, U.S. CONGRESS COMMISSION ON EDUCATION FOR THE DEAF, HEMPSTEAD, NY

Senator **Harkin**. Next is Professor Frank Bowe of Hofstra University.

Is Dr. Bowe here from Hofstra?

There he is. Good morning.

Dr. **Bowe**. I was out in the hall, sir.

Senator **Harkin**. Were you talking to Patty Duke?

Dr. **Bowe**. No; I do not work on that level, sir.

Thank you, sir. It is a pleasure, it really is.

I wanted to be able to testify to a few things that are very important to people who are deaf and have other disabilities.

We have been making some progress, as you know, since my commission completed its work, and several things have begun to move forward that we need appropriations for. The first I would like to talk about would be severely handicapped, multiply disabled low achieving deaf adults. There is little or nothing out there for them, and we really do need as Dr. Castle testified April 4 some funds for that population. It is desperately needed, and I would like to support his recommendation for $1.8 million for a one-time appropriation that would demonstrate those kinds of services.

We have also, as you know, in the commission identified some very serious needs in postsecondary education, particularly the four regional postsecondary programs, and my commission asked them to do more than they were previously doing. They have agreed to do that, but their funding has not been increased.

There was a danger that the traditional work which had been excellent might have to be sacrificed because they were doing additional responsibility with no more funds. Further, I strongly want to recommend that their funding be increased.

We had two other things I wanted to point to this morning as urgent needs that I feel are of tremendous importance. The first is the development and testing of chips that would be in every television set.

What the Department of Education has done is to issue another contract to provide some money to help pay for separate boxes, separate decoders. Our commission believed that is definitely now what is needed.

What we need now is money to develop and test a chip that would cost about $5 maybe $10. That is the direction in which we should be moving and, if necessary, I believe that the existing contract which has not yet been awarded should be canceled and those funds should be used to support the development of a chip. If that is not done this year, then I do believe very strongly that about $1 million should be appropriated to support the development and testing of a chip. That would mean that it would be able to be used with any television set because the testimony would make it compatible.

My last point is the need for interpreters for people who can use sign language, we started that at Gallaudet last June, a tremendous growth in the willingness and the ability of people who are deaf to go out into the mainstream where I have spent most of my life, and they are discovering, as I have, that you cannot really do that without interpreters. We simply do not have anything close to the number of interpreters we need, and we do not have anything near the number of people who have taken basic sign language courses. I am talking about bank tellers. I am talking about stockbrokers. I am talking about sales clerks learning some basic signs so they can communicate. Like if I go to a restaurant, a waiter would at least be able to say the special of today is and that kind of thing. And you see them doing that in Spanish, but you almost never see it in sign language.

PREPARED STATEMENT

I have recommended in my written testimony some specific places where you can find the funds for this. I just want to personally express my very deep conviction that as we move forward with the Americans With Disabilities Act which will vastly expand demand for both sign language schools and interpreters, we are going to need those people out there, and if we do not have them, then the Americans with Disabilities Act would be effectively meaningless for those who are deaf.

I see that the light is on, so I had better shut up. I want to thank you for the opportunity to testify, sir.

[The statement follows:]

STATEMENT OF DR. FRANK G. BOWE

Good morning. It is a genuine pleasure for me to testify today before this Subcommittee and its distinguished Chairman, Senator Tom Harkin of Iowa. I am testifying today for increased funding of several severely under-funded programs benefiting people who are deaf, many of whom have additional handicaps.

I wish to express my support for the testimony presented to this Subcommittee on April 4 by Dr. William Castle of NTID for $1,800,000 to demonstrate services for severely handicapped deaf youth and adults. As Chairperson of the US Congress Commission on Education of the Deaf 1986-1988, I learned first-hand of the urgent and immediate need for such services. The statistics Dr. Castle presented mirror those reported by my Commission and they are, Mr. Chairman, truly shocking figures: we have failed this population. There is no more gentle way to put it.

The four Regional Postsecondary Programs for Education of the Deaf [RPEPDs] already are assuming the additional roles the Commission recommended they be given, yet their funding has not increased to reflect that extra work. It is urgent that they be funded at a level sufficient to permit them to perform: [1] the work they traditionally have done pursuant to Part C, section 625(a)(1) of the Education of the Handicapped Act [EHA], as amended; [2] the new responsibilities they have accepted; and [3] the work proposed in Dr. Castle's testimony. I recommend that authorizations under section 625(a)(1) be increased from just over $2 million to $3.0 million [exclusive of the $1.8 million one-time appropriation for severely disabled deaf persons] to accommodate the additional roles the RPEPDs are playing pursuant to the Commission's recommendations. This would provide to each RPEPD about $200,000 additional dollars, which is what they need. Each now receives, on average, about $500,000.

The Commission identified a solution to a decade-long problem in closed captioning. We recommended that a decoder chip be placed into commercial television sets. You, Mr. Chairman, have been kind enough to state that you plan to introduce legislation for this purpose. What is needed now, through the appropriations process, is to provide $1,000,000 for development and testing of such chips. The chips must be designed and then they must be made to fit in with the hardware and software of different manufacturers' television sets. These two tasks would produce, within 12 to 18 months of provision of funding, the capability in the television industry to equip future generations of TV sets with built-in decoder capabilities. Current work on decoders is funded through contracts administered by the Department of Education's Media Services and Captioned Films Branch in OSEP; that is an appropriate vehicle for chip development and testing, although the work may also be funded under SBIR [small business innovative research] contracts.

My Commission also identified a nationwide shortage of interpreters at all levels. There is authority under Part D of the EHA which could be, but to date has not been, used to support interpreter training. I am testifying in support of this Subcommittee earmarking $5,000,000 for section 631(a)(1)(B) for training educational interpreters as persons who provide "related services to handicapped children and youth in educational settings", and more generally in support of the Council for Exceptional Children's testimony requesting $150-million for Part D to resolve urgent personnel shortages. I would respectfully request that the former figure be earmarked specifically for interpreter training, to ensure that it is used for this purpose.

Section 304 of the Rehabilitation Act of 1973, as amended, is the only current source of federal money to train interpreters. Funding for these programs has been minimal. Just ten (10) centers are supported, at an annual level of $90,000 each. That clearly is far from sufficient. In New York City alone, more than 10,000 hours of interpreter services were denied last year due to a shortage of interpreters. The need for interpreters in the New York-New Jersey area is severe. Hofstra University, on Long Island, is prepared to inaugurate an interpreter training program and to compete for funds to support it; but section 304 appropriations for this purpose are so minimal that our gain would be other regions' losses absent more funds. It is urgent that section 304 interpreter funds be at least doubled to $2,000,000 to enlarge the capacity of existing programs and to support several new ones, pursuant to COED Recommendation #37.

Section 315 of the Rehabilitation Act of 1973, as amended, offers specific authority for the Department of Education's RSA to provide grants to States for establishing interpreter services. It has never been funded. That section also authorizes the RSA Commissioner to establish standards for interpreters in rehabilitation; such standards never have appeared due to the zero-funding of this section. COED Recommendation #38 specifically asked Congress to fund section 315 and to require the Department to issue the standards called for therein. I am testifying in support $5,500,000 to implement this recommendation, which would provide an average of $100,000 per State to support rehabilitation-related interpreting services, and $500,000 to the Department to develop and form nationwide consensus around rehabilitation interpreter standards. The Department should be permitted to let a contract under competition for the consensus-building and standards-developing work.

In Recommendations #34 (on preparation of educators to work with deaf children) and #39 (on preparation of rehabilitation personnel to work with deaf youth and adults), the Commission pointed to an urgent need for something else -- for qualified personnel who are able to communicate with deaf people. Additionally, in Recommendation #15, the Commission recognized American Sign Language as a legitimate language on a par with French, German, and English. Appropriations of funds earmarked to support beginning and intermediate sign-language instruction in inservice training for public schools personel, in teacher training undergraduate and graduate programs, and in rehabilitation counselor undergraduate and graduate programs and in programs preparing job coaches for work in supported employment settings urgently is needed. I am testifying in support of $1,000,000 to demonstrate sign-language instructional programs under Part D of EHA and an additional $1,000,000 to demonstrate sign-language instructional programs under Title III of the Rehabilitation Act, as amended. These monies are for sign-language instruction; that is distinct and apart from interpreter training.

The Commission recommended [#15] that the Bilingual Education Act certify American Sign Language as an approved "native language". This is especially important because the EHA defines "native language" by referencing that approved list. I respectfully request that this Subcommittee work with the authorizing committees involved to make the necessary arrangements so that American Sign Language becomes an approved language for which appropriations may be made in future years.

Mr. Chairman, with appropriations this year on interpreter training and sign language instruction, deaf people will be able fully to enjoy the nondiscrimination protections afforded by section 504 and those envisioned by the draft Americans with Disabilities Act. People able to communicate with us -- tellers, sales clerks, nurses and lawyers possessing basic skills -- and interpreters who work with us are our ramps and elevators. We need them in order to gain access to the American dream.

Thank you.

Senator HARKIN. Thank you very much, Professor Bell—Frank, as I know you. This is obviously an area that you know I have a specific and special interest in. All I can tell you is that we will do everything we can to meet the needs. I am going to do everything I can to get the chip moving forward and to provide as much as we can for interpreter training.

Many times, not only just in the things that you have mentioned, in restaurants and any other place, but especially in our justice system, people are brought into court and do not really understand what is going on because it is hard to get an interpreter and I want to make sure that we meet those needs too. We will do our best.

Dr. BOWE. Thank you sir, I appreciate it.

Senator HARKIN. Thank you very much.

STATEMENT OF DR. O. ROSS McINTYRE, PRESIDENT, ASSOCIATION OF AMERICAN CANCER INSTITUTES

Senator HARKIN. Next, we will go to Dr. Ross McIntyre, president of the Association of American Cancer Institutes.

Dr. McIntyre. Thank you, Mr. Chairman.

I am this year the president of the Association of American Cancer Institutes, an organization which represents all of America's major cancer institutes.

For the last several years we have appeared before this committee to request attention to the National Cancer Institute budget and with particular reference to the center's program within the National Cancer Institute.

Last year, because of the committee's desire to learn more about the cancer center's program and its current state, the committee inserted language into the bill requesting that the Institute of Medicine of the National Academy of Sciences undertake a study of the cancer center's program.

I have a copy of that committee report with me this morning and I do not know whether you have had time to receive it or not, but I would like to read a portion in it which gives me some credibility, I hope, as I describe the sorry state of affairs with respect to our National Cancer Center program.

This is the Institute of Medicine Committee report which recommends that the longer-term role of the cancer center core grant program and the National Cancer Program should be the subject of an intensive planning effort. Immediate steps should be taken, however, to ensure that high-quality cancer centers do not lose their core grants for lack of program funding.

The committee recommends that the director of the National Cancer Institute take immediate steps to avert a crisis in the funding of the program during the current fiscal year—that is, 1989.

The committee recommends further that the Directors of the NCI and the National Institutes of Health and the Secretary of the Department of Health and Human Services work with the appropriate committees in Congress to develop an adequate budget for the program's next fiscal year, 1990.

Otherwise the committee is concerned that the projected funding levels for the core grant program this year and next will result in the loss of centers with excellent peer review priority scores before the program planning process is completed.

What we are really talking about here—and I believe you have heard in testimony from the Director of the NCI—is that probably five cancer centers this year will go down, will be lost, and another five will be lost in 1990 unless steps are taken to correct this fiscal emergency.

PREPARED STATEMENT

This represents nearly 20 percent of the overall cancer center program in this country and destroys the possibility that developing new centers in areas which are currently underserved with respect to cancer research and cancer services will develop. It is a serious problem and I thank you for your attention to it.

[The statement follows:]

STATEMENT OF DR. O. ROSS MCINTYRE

Mr. Chairman and Members of the Committee, I appreciate appearing before you, as President of the Association of American Cancer Institutes (AACI), an organization that represents all the major cancer centers in the nation.

I am O. Ross McIntyre, M.D., Director of the Norris Cotton Cancer Center in Hanover, New Hampshire, and President of the AACI.

Mr. Chairman, the cancer centers core grant program of the National Cancer Institute is in very serious trouble.

Several weeks ago the Director of the National Cancer Institute appeared before you. In response to your questions about cancer centers he indicated that five competing cancer center core grants may not be funded in fiscal year 1989 and, if the President's Budget is agreed to by this committee, another five at least may not receive funds in fiscal year 1990.

That means, Mr. Chairman, that 10% of the cancer centers of the country that have core grants from the NCI would be lost in this current fiscal year, and an additional 10% will be lost in fiscal year 1990 unless something is done about the Administration budget proposal.

In recent years we have testified to this committee that there has been a severe deterioration of the Cancer Centers Program of the National Cancer Institute. This matter became of such concern last year the Senate Subcommittee on Labor-HHS-Education Appropriations called for a study by the Institute of Medicine on the subject. Although that report will not be released until three days from now, we know that it will be very strongly supportive of the cancer centers program. It almost certainly will urge very rapid action to ameliorate the crisis that is occurring in this current fiscal year, and next fiscal year as well.

CANCER CENTERS PROGRAM BUDGET LEVELS IN RECENT YEARS

Last year we testified that there had been a decrease of 10% in constant dollar support for the cancer centers program between 1980-1987. We also indicated that the President's proposed budget essentially "straightlined" the cancer centers program funding for fiscal year 1989 and, in fact, that did occur. This year the President's budget once again essentially proposes a "straightlining" for the cancer centers program, but this will not happen because it is expected that the NCI will decrease cancer center funding by about $1 million in order to meet the President's proposal that basic research grants be increased by approximately 6% -- that increase would be taken directly out of budget lines of the cancer centers program, and similar programs, at the NCI. (As the Budget Justification for the NCI states, p. 128, "The 1990 estimate of $98,057,000 represents a decrease of $1,195,000 from the 1989 estimate".)

HISTORICAL BACKGROUND

The Cancer Centers Program of the National Cancer Institute has been in existence for over a quarter-century. Throughout this period, and especially after the passage of the National Cancer Act in 1971, the Centers increasingly became a vital part of the National Cancer Program. Many major research advances have occurred in these centers.

The U. S. Congress, in over 50 formal statements since the inception of the program, in authorization and appropriations legislative action, as well as in debate on the floors of both houses, has given strong and unwavering support to the program, and has called for additional services, including cancer control. The intensity of congressional expression of concern has increased since 1982, as the Congress itself has begun to be aware of the lack of Administration support since then.

At the same time, 1982 marked the beginning of a systematic administrative downgrading by the NIH/NCI of the Cancer Centers Program, with subsequent loss of identity and advocacy within the Institute.

The Cancer Centers Program was reorganized and placed in a division at the National Cancer Institute which lacked the word "Centers" in its title; there has been a steady erosion of the amount of cancer centers funding as a percentage of total NCI funding from approximately 8% down to 6.8% in fiscal year 1988, and less than that for fiscal year 1989, and still less is proposed for FY 1990.

Coincident with this, administrative decisions resulted in funding grant renewals at 85% of the amount recommended by peer review and, despite this action three years ago, four centers were funded only by a congressional supplemental appropriation. Now there is a similar threatened loss of centers in FY 1989. This situation has placed very severe strains upon the cancer center infrastructure, the loss of major research opportunities, and certainly will prevent the Nation from reaching the goals laid down for the National Cancer Program.

We fully understand that this committee has never had a desire to "micromanage" the NCI or any of its programs, and that it depends upon the NCI to manage appropriately the funds given to it. However, as is indicated in our statement for the Institute of Medicine study, the systematic administrative downgrading and seriously damaging levels of funding of the Cancer Centers Program must be corrected, and we are hoping, whether by specifying funds for the Program, or by some other mechanism, this committee will take steps to rectify the problem.

JUSTIFICATION FOR INCREASING CENTER FUNDING

Allow me to comment more specifically as to why this committee should now intervene in this matter by increasing funding:

A. The philosophy of those who designed and implemented the Centers Program within the NCI was that core funding represented an efficient means of promoting interdisciplinary science relating to cancer.

An analysis of the five hundred and seven shared research services offered to investigators by fifty-seven cancer centers, in fiscal 1987, reveals that these are facilities which generate wide usage by peer-reviewed and funded investigators on the staff of the centers. The heavy use of efficiently managed core facilities results in net savings, if compared to the cost of operating these facilities on an individual basis using support from R01 budgets.

B. Relative to R01 and P01 support from the NCI, which has increase 49.7% between 1983 and 1988, cancer center core grants have increased by 36%. This caused substantial cutbacks in peer-reviewed core grants and centers necessarily have responded by curtailing shared services which they intended to develop. Now, centers are going to be lost from the program and newly developing centers are not going to be funded. There are 15 approved but unfunded construction grants pending and the NCI construction program has not been funded for years.

C. The cancer centers serve as important training sites for young cancer researchers who will staff our laboratories and clinics in the next decade. Cutbacks in the number of training slots supported by the NIH has forced cancer centers to expend local resources to take up the slack.

D. The best (if not perfect) method to assess what funds are appropriate for a given center is peer review. Administratively imposed reductions in core grants by the NCI from the peer reviewed and recommended amounts have been the rule in recent years despite the expressed concern of the Congress about such reductions. Administrative cutbacks in awards from the peer reviewed level in order to fund additional centers nullify an important element in peer review, that is of appropriate funding for the tasks to be accomplished. Increasing competition for funds induces centers to promise more than can be delivered with adverse consequences in public relations, and relations with the Congress and with one's peers at the time of next review. Funding for centers must be commensurate with what is asked of centers. To ask for more with less funding support leads to loss of opportunities, and credibility as well.

E. The NCI's expectations for cancer centers have increased, particularly in the area of rapid translation of research findings to clinical practice, and in cancer prevention.

Expansion and addition of new activities cannot be undertaken with what has been a diminishing level of NCI core support in constant dollars since 1980.

F. The Division of Cancer Prevention and Control, the NCI Division which holds responsibility for the Centers Program, has had substantial loss of senior staff, a condition which has also afflicted other NCI divisions. This has had a serious effect upon the management of the Centers Program.

G. To the American public a cancer center represents, as it appropriately should, a site at which the best and most modern methods for cancer diagnosis and patient management are available. To the scientific community the cancer centers are institutions with a major commitment to the support of a broad range of cancer research. In keeping with concerns for the health of the public, the cancer centers collectively represent the single largest and most effective network through which to investigate the causes and prevention of cancer, and to assist in the application of this knowledge.

H. Those of us in the private sector are highly appreciative of the devoted efforts of those talented scientist-administrators who have given themselves to the work of the NCI without regard to the personal sacrifices this entails. Because such devotion may be limited to years rather than decades, we urge that the situation regarding pay levels be corrected before quality of work at the NCI suffers.

RECOMMENDATION

We recommend:

For the Cancer Centers Program:

a. FY 1989--To fund the centers likely to be defunded this year $5-6 million (to fund at 85% recommended levels), or $18 million (to fund at full peer-reviewed recommended levels) would be required. Funds would have to be found from within the NCI current budget, or be added in the FY 1989 supplemental--for a total Cancer Center Program budget of $118 million, instead of $100 million presently. If defunded, some may recompete next year.

We recommend, if at all possible, that in the current supplemental appropriation making its way through Congress, an additional $6 million to be made available for funding, in FY 1989, those center core grants which have fundable scores but which cannot be funded because of insufficient funds, or that funds be found elsewhere from the NCI budget.

b. FY 1990--To fund the 5 or so additional centers likely to be lost under the President's budget, an additional $5-6 million will be necessary (to fund at the 85% level), or $18 million (to fund fully). Total budget for FY 1990 would be $135 million instead of $99 million. (Total assumes inclusion of 5 centers due to be defunded this year.)

c. We recommend strong supportive bill report language for the Cancer Centers Program.

For the National Cancer Institute:

a. We recommend the By-Pass Budget level of $2.195 billion (excluding AIDS funding). That is a funding level which will provide for appropriate levels of research project grants, clinical research, clinical cooperative groups, construction, and training of new investigators.

b. However, we understand that this committee may not be able to fund to that level and therefore support the proposal of the National Coalition for Cancer Research.

For the National Institutes of Health, we recommend $8.4 billion, a figure supported by the Ad Hoc Group for Medical Research.

Thank you for allowing us to present our case to you.

Senator HARKIN. Thank you very much. Could you tell us again, Dr. McIntyre, in just one sentence or as succinctly as possible, why is it necessary to have all these centers? Why can we not close down five or six of them?

Dr. MCINTYRE. I think the public regards cancer centers as a place where when a serious cancer problem emerges, that good information about the current state of treatment and current research is going on with respect to that person's problem and as a cancer center director, every day I get calls from around my region and sometimes further away, of people with desperate problems who are seeking good advice and looking for the state-of-the-art treatment to try to retrieve a situation which is otherwise fatal.

Senator HARKIN. When I had NIH up the other day, I had a figure in front of me—I do not have it right now—about how many cancers were misdiagnosed in the beginning that could have been treated, perhaps cured, if they had been properly diagnosed.

We have all this information, but for some reason it is not getting out to the doctors' offices for proper diagnosis. We have had these centers for a quarter of a century. They are supposed to have that information. Why is it not getting out to doctors?

Dr. MCINTYRE. I think that the cancer centers are doing a pretty good job of getting it out to the doctors, but diagnosing cancer is not easy in the complex cases and the doctors who are out there in the community need a reference place to which they can send difficult problems.

I think the other thing that cancer centers increasingly are doing, which is even more important, is getting the word out to the public of how to prevent certain cancers. Obviously, the way to handle a cancer problem when we know the answer to prevention, is to prevent it.

Senator HARKIN. I agree. I just wanted to get that on the record. I agree with you. I just want to make sure we get it on the record. Thank you very much.

PREPARED STATEMENT OF DR. KAREN ANTMAN

Dr. McIntyre. I also have been asked by Karen Antman from the American Society for Clinical Oncology to insert a statement from her in the record, representing the views of ASCO, the American Society of Clinical Oncology, the largest group of scientists and clinicians in the cancer area. So I will turn in this statement. Thank you.

Senator Harkin. Without objection, we will do that, Dr. McIntyre.

[The statement follows:]

STATEMENT OF DR. KAREN ANTMAN

Mr. Chairman, I am Karen Antman, M.D., an Associate Professor at the Dana-Farber Cancer Institute and Harvard Medical School in Boston, Massachusetts. testifying today on behalf of the American Society of Clinical Oncology (ASCO).

The American Society of Oncology, founded 20 years ago, is the largest organization of physicians and scientists specializing in cancer, including prevention, treatment, teaching and research. Its members include the nation's leading physicians in medical and pediatric oncology, radiation therapy, surgical and gynecologic oncology, and also basic scientists in pathology, immunology, pharmacology, biostatistics, and other basic biomedical sciences, in literally all of the nation's medical schools, cancer hospitals, centers and institutes.

First, Mr. Chairman, ASCO would like to thank you and your committee for your continued strong support for both the National Cancer Institute and the National Institutes of Health in the past, and particularly last year. Your support is particularly noteworthy in this era of budgetary restraint. We are deeply grateful.

RECOMMENDATIONS ON APPROPRIATION LEVELS

Mr. Chairman, we strongly support for the National Cancer Institute (NCI) a funding level of $2.180 billion, with an additional $155 million for AIDS research in the NCI, i.e., a total of $2.195 billion. This is the so-called "By-Pass Budget Request" prepared according to the National Cancer Act of 1971 (as amended) authorization requirements. However, as we understand the budget constraints under which this committee is working, if your committee cannot fund at this level we would indicate that at least the level of funding recommended by the National Coalition for Cancer Research be granted.

In a recent survey of our members, the number one priority stressed repeatedly was funding for clinical trials. Virtually all clinical trials are conducted in cancer centers and in the cooperative clinical research groups. Thus, we support the By-Pass Budget call for an increase of funding for cancer centers. Although the By-Pass Budget requests the initiation of five new centers in 1990, it is our belief that the cancer centers currently in place should be funded at full peer reviewed levels, and a sufficient amount of funding should be made available to prevent the loss of cancer centers which otherwise would have their grant proposals renewed if there were sufficient funding.

Furthermore, we support the By-Pass Budget's increase of $20.8 million for clinical cooperative groups, which would assist in doubling patient accrual into clinical trials by 1992.

We also support an increase of $15.9 million for training to support 1,800 trainees through the National Research Service Award Program. (This committee is well aware of the problems introduced by the increase in stipend awards in fiscal year 1989. We fully understand that this committee was not responsible for the transfer of funding into stipends, and in fact could do nothing to deal with that issue in fiscal year 1989.) The By-Pass Budget would also provide $221.4 million for research grants which would fund 50% of approved competing research project grants at recommended levels. Of particular concern is the rapid decline in the number of competing research projects (R01's, P01's, etc.), excluding AIDS, as shown in the table below.

FY Year	Number
1985 Actual	999
1986 Actual	926
1987 Actual	1,053
1988 Actual	970
1989 Estimate	682
1990 President's Budget	792

These figures are extraordinary, especially from fiscal year 1987 through fiscal year 1990 (as proposed in the President's Budget).

RECOMMENDATIONS FOR CLINICAL RESEARCH

Mr. Chairman, you will recall that in its report on the fiscal year 1989 budget for the Department of Health and Human Services, the Senate Committee on Appropriations stated,

> "Clinical research which permits the evaluation of new therapies is a vital element of the Cancer Research Program. However, several difficulties are emerging in the pattern of clinical research which may hamper these valuable studies. For example, there is increasing difficulty in recruiting patients for these trials; additionally, because research patients frequently are more seriously ill than others who might be hospitalized for the same illness, appropriate and needed care for them tends to be more expensive. Currently this additional cost is not reimbursed by research grants, and frequently is also not reimbursed by third-party insurance carriers. The Committee therefore requests NCI to evaluate the seriousness of these difficulties and to report to the Committee, prior to next year's hearings, as to what remedies might be available and the costs involved." (Senate Report No. 100-399, page 93)

We understand the NIH's response has been sent to all members of the committee and to staff.

The American Society of Clinical Oncology strongly supports the recommendations made in that NIH report. There were two particularly important issues, patient accrual to clinical trials and the impact of third-party reimbursement policies on clinical trials.

The two issues are clearly interrelated.

Impact of Third-Party Reimbursement Policies on Clinical Trials: We support strongly the NIH's recommendations regarding this matter, which begin on page 7 of the report they have made to the Congress.

As is indicated in the report,

> "Most third-party insurance contracts explicitly exclude payment for patient-care costs associated with investigational drug research. The research exclusion has been part of most insurance contracts for many years but has not been rigorously enforced, probably because of substantial difficulties in monitoring the delivery of medical care. Recently, however, with the increased emphasis on cost containment, insurance companies have had an increasing tendency to deny claims where an investigational agent is clearly part of the therapy. The claims that are denied are not simply the additional costs of care over and above that of standard therapy, but may include the entire cost of the hospitalization, irrespective of what the cost would be without the investigational treatment."

There are two other very important statements made in the NIH report to the Congress and are contained on page 9 of the report:

> "NCI's point of view on this problem can be simply stated. We believe that, in the treatment of cancer, patients on clinical trials receive therapy that is quite likely to be at least equivalent to or possibly better than standard treatment. Indeed, the NCI believes and is working hard to promote the concept that clinical trials do in fact represent standard treatment for cancer patients where no curative therapy exists. The reason is that most trials in advanced disease compare a new therapy believed superior to standard treatment, to the accepted standard.

> "The treatment offered them on ethical, scientifically valid clinical trials represents, therefore, the best approach medically that can be offered. For these reasons, we consider it appropriate for third-party carriers to reimburse patients for the medical care costs of participating in scientifically valid clinical trials. Note that this approach does not depend on the societal value of clinical research, which is self-evident, but rather on the conviction that, at any stage in the course of a particular patient's cancer, participating in clinical trials is the best approach medically that can be offered to that patient."

Additionally, as reported by the NIH, a number of organizations have gathered for a series of meetings on this issue. They include the American Society of Clinical Oncology, National Coalition for Cancer Research, American Medical Association, Pharmaceutical Manufacturers Association, Association of Community Cancer Centers, Institute of Medicine, Food and Drug Administration, and various volunteer national organizations such as the Candlelighters. We expect a consensus report from that group shortly.

Patients who have insurance which would pay for standard therapy are unlikely to volunteer to participate in clinical trials if they then are required to pay for the patient care component of their care. (The research costs are paid by the study sponsor, e.g., the NCI.) However, increasingly when the cancer cannot be cured with best standard therapy, and experimental treatment provides the only hope, patients have paid for such therapy themselves. Since many Americans do not have this option, the issue then becomes one of access to medical care.

Major Problem: A major problem, Mr. Chairman, which would be of concern to you, is that the Health Care Financing Administration (HCFA) currently does not reimburse for these clinical research costs. I quote from page 10 of the NIH report:

> "NCI has also met on two occasions with staff of the Health Care Financing Administration (HCFA) concerning its policies for Medicare. Currently Medicare policy is to exclude investigational therapy from coverage, since HCFA believes that treatment with agents not yet approved by the Food and Drug Administration does not satisfy the 'reasonable and necessary' criterion included in the legislative language relating to Medicare. Despite this exclusion, Medicare does pay for certain limited categories of care relating to investigational therapies.

Comment: Mr. Chairman, this is a vitally important matter to be resolved, because it already has had a profound negative affect on clinical research.

Recommendation: We are requesting that this committee develop bill report language calling upon HCFA, which this committee funds, to work closely with the NIH and other interested parties in moving toward resolution of this problem. We would be happy to review or recommend such language.

We are also working with HCFA itself, and with the Senate Finance Committee and House Ways and Means Committee on this issue as well.

STATEMENT OF DR. THOMAS A. WEINGEIST, UNIVERSITY OF IOWA COLLEGE OF MEDICINE, IOWA CITY RESEARCH TO PREVENT BLINDNESS

Senator **Harkin**. I will take one person out of order, because I understand he has a plane to catch. Dr. Thomas Weingeist, University of Iowa College of Medicine, Iowa City Research to Prevent Blindness. If the other witnesses out there that have planes to catch that have to get some place, if you would let our staff know I would be delighted to also extend that courtesy to you.

Dr. Weingeist, if you could please summarize your statement.

Dr. **Weingeist**. Senator Harkin, I appreciate being able to come a little bit early before you.

I am Dr. Thomas Weingeist, professor and head of the Department of Opthalmology at the University of Iowa in Iowa City and it is my pleasure to present the citizens' budget for the fiscal year of 1990 for the National Eye Institute. This is being done under the auspices of the Research to Prevent Blindness, the world's leading voluntary organization in support of vision research.

In 1976, when I completed my formal medical training, there was no established treatment for diabetic retinopathy, the leading cause of blindness among individuals under the age of 60. Nor was there any means of preventing or treating macular degeneration, which is the leading cause of blindness among citizens over the age of 60.

Now, in less than 15 years all that has changed due to the wise and judicious use of funds which you have provided to the National Eye Institute for vision research. But unfortunately, blindness is still a major problem. There are some 80 million Americans who suffer from eye diseases, some 14 million who are afflicted with severe life-disrupting loss of sight, not correctable by eye glasses or contact lenses, and it is estimated that some 500,000 Americans are blind.

The only hope of reducing this enormous human toll and of holding in check the estimated $16 billion in the cost of eye disorders and blindness, really lies in eye research. I would like to take a few moments to highlight several of the points in my written testimony and while I am doing that ask you to budget the value of the support Congress has given for eye research by providing funds to the National Eye Institute, not only in terms of the dollars returned on the investment, but more importantly on the quality of life for literally millions of Americans.

There are 11 million citizens who have diabetes in the United States. It is estimated that some 40 percent of them will have visual complications. Clinical trials sponsored by the National Eye Institute have pioneered several treatments which will delay or prevent the loss of vision in these diabetic patients. Clinical trials of laser therapy for diabetic retinopathy cost $10.5 million and have resulted in an annual savings of over $450 million.

Now, as the U.S. population ages, age-related macular degeneration increases. Age-related macular degeneration is now the leading cause of blindness in the United States. New methods of treatment now make it possible to delay or to prevent the onset of blindness in some 75 percent of individuals who have one form of macular degeneration associated with aging.

The NEI trial cost $1.57 million and it is estimated that that has resulted in a savings of $75 million annually. Now, clearly the investment in these clinical trials was worthwhile.

The eye is truly a window of the body. Diseases like diabetes, hypertension, AIDS, cancer and even Alzheimer's Disease may initially be detected by changes in the eye. Basic research involving the eyes has far greater implications than preservation of vision alone.

Basic scientists supported by the NEI grants have now identified a specific gene related to retinal blastoma, which is a blinding, life-threatening tumor affecting children. Researchers have worked on lasers which have clinical applications in other areas—in cardiovascular surgery, in neurosurgery. NEI-supported grants are now helping——

Senator HARKIN. If I could ask you please to summarize.

PREPARED STATEMENT

Dr. WEINGEIST. To support research related to AIDS. I would like it if your committee would consider approving the citizens' budget, which is $312,457,000 for the fiscal year of 1990. The proposed expenditures are shown in each category in the appendix.

Senator HARKIN. I have it.

Dr. WEINGEIST. I appreciate being able to come before this committee. I would be happy to try and answer any questions that you have.

[The statement follows:]

STATEMENT DR. THOMAS A. WEINGEIST

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE: I am Dr. Thomas Weingeist, Professor and Head of the Department of Ophthalmology at the University of Iowa College of Medicine. It is my privilege to present the Citizens' Committee Budget for Fiscal Year 1990 under the auspices of Research to Prevent Blindness (RPB), the world's leading voluntary organization in support of vision research.

Sight is our richest sense, our primary link to the world. Seventy-five percent of what we perceive comes to us through our eyes. When this remarkable organ functions normally, we behold our physical environment to the horizon and to the stars beyond. When it fails the world quite literally ends at our fingertips. We suffer the devastating loss of security, mobility, and independence.

Gallup Surveys sponsored by Research to Prevent Blindness in 1965, 1976, and again in 1988, have found repeatedly that the disability Americans fear most is loss of sight. Moreover, when compared to the major catastrophic diseases that can afflict mankind, blindness ranked fourth behind AIDS, cancer, and Alzheimer's disease. This fear of blindnesss is justified. Eighty million Americans suffer eye diseases, and more than 14 million are afflicted with severe life-disrupting loss of sight not correctable by eyeglasses or contact lenses.

According to National Health Interview Surveys, blindness and visual impairment are the third leading cause of disability in non-institutionalized Americans. Nearly 1.5 million need help with personal care, meal preparation, shopping and other routine daily living activities. More than 500,000 are legally blind. The only hope of reducing this enormous human toll -- and of holding in check the $16 BILLION annual cost of eye disorders and blindness -- lies in eye research.

The Citizens' Committee has placed before you a solidly constructed budget proposal for Fiscal Year 1990 based upon recent achievements and those areas of current need, which -- perhaps for the first time -- can now be exploited with powerful new advances in biotechnology. This is not a "wish list", but represents realistic opportunities whose exploitation warrants your support.

For example, scientists at Columbia, Wake Forest, and the University of California recently demonstrated for the first time that healthy retinal cells transplanted to the retina in animal studies can halt degeneration in diseased eyes. This remarkable achievement holds the promise of an eventual cure for retinitis pigmentosa and other degenerative retinal diseases such as **AGE-RELATED MACULAR DEGENERATION (AMD)**. AMD is the most common cause of blindness in persons over 60. As the U.S. population ages, this insidious disorder could affect 6.3 million Americans by the year 2030 -- more than double the prevalence of just twenty years ago. The Citizens' budget calls for an expansion of photoreceptor transplantation research toward the eventual development of a cell replacement therapy that could save the sight of millions of Americans in their retirement years... and conserve billions of tax dollars that would otherwise be necessary for social, rehabilitative and other support services.

Unfortunately, the risk of blindness is ever present. Working Americans face the possibility of severe vision loss and, perhaps, an abrupt change in career from a variety of eye diseases for which we must find adequate controls. The major cause of blindness and visual disability in adults under 60 is **DIABETIC RETINOPATHY**. Eleven million citizens have diabetes and forty percent of them will have visual complications. Clinical trials sponsored by the National Eye Institute have pioneered several treatments to delay or temporarily reverse loss of vision from diatetes. The first of these, the **DIABETIC RETINOPATHY STUDY (DRS)** now completed, cost $10.5 million. The second, the ongoing **EARLY TREATMENT DIABETIC RETINOPATHY STUDY (ETDRS)**, cost $37.7 million from 1977 to 1986. This investment is minuscule when compared to the potential savings from the widescale application of successful therapies developed in just these two clinical trials. A recently devised computer simulation model projects that the cost of treatment for each year of useful sight preserved is only one-seventh the annual cost of Social Security Disability (SSDI) payments made to each worker disabled by diabetic blindness. The National Eye Institute estimates that the cumulative savings in the cost of direct patient care, non-medical expenses and lost productivity due to the ocular complications of diabetes could be as high as $2.3 BILLION over the next five years alone.

But the greatest cost benefit, and the ultimate hope for patients living under the threat of blindness from diabetes, is in prevention. Eye researchers have established the central role of an enzyme, aldose reductase, in the onset of eye disease and other systemic complications of diabetes. The Eye Institute has also developed the first reliable animal models of diabetic retinopathy. The models mimic precisely the early blood vessel lesions typical of diabetic retinopathy in humans. More importantly, these animal studies have shown for the first time that the lesions can be prevented and vision can be saved by newly-developed drugs that inhibit aldose reductase production. Inhibitor drugs have potential for the control not only of diabetic retinopathy but of cataracts related to diabetes.

CATARACT, of course, has multiple causes. Sixty percent of Americans between ages 65 and 74 show some sign of the disease. More than one million cataract operations are performed each year and the number could reach two million in less than a decade. If we could delay development of cataract by 10 years, the annual savings would exceed $600 million. A Johns Hopkins study of Chesapeake Bay fishermen supported by the Eye Institute recently concluded that high exposure to the sun's ultraviolet B radiation can more than triple the risk of developing one form of the disease. UV-blocking eyeglasses and eye-shading headwear that limit sun exposure can reduce this risk, but increased support of research into metabolic factors and photochemical processes is critically needed if we are to reduce significantly the prevalence of lens opacities that today impair the vision of more than 3.5 million citizens.

Mr. Chairman, the importance of eye research in providing broad insights in other fields deserves particular mention. Vision scientists at Harvard were the first to identify and clone the gene for a human cancer, retinoblastoma, the most common eye cancer in children. As a model for recessive cancer genes, the Rb gene has become the most studied of oncogenes and is now implicated in bone cancer and in certain cancers of the breasts and lungs.

At the University of Iowa, we are participating in and analyzing photographs for the **COLLABORATIVE OCULAR MELANOMA STUDY** (COMS) to evaluate two methods of treatment for choroidal melanoma. This is the most common eye cancer in adults, and often leads to the surgical removal of the affected eye. We have made progress at Iowa in developing an animal model for ocular melanoma -- an important step in the search for an eventual cure for this and, perhaps, other systemic melanomas. The COMS clinical trial sponsored by the Eye Institute will determine the role of radiation therapy in saving the lives as well as the sight of patients with malignant melanoma of the choroid.

Our department also participates in a national study of the medical treatment for cytomegalovirus retinitis, the most common ocular infection in the **ACQUIRED IMMUNODEFICIENCY SYNDROME** (AIDS). Up to 50% of all AIDS victims experience the serious visual complications of this disease. Vision scientists are striving to avert the devastating loss of sight that accompanies AIDS so that prolongation and eventual saving of these lives will not leave them hopelessly blind. These studies are contributing significantly to the field of virology and to understanding immune processes that lie at the root of the AIDS infection and many other as yet uncontrollable eye diseases.

HERPES SIMPLEX VIRUS (HSV-1) corneal infection is especially onerous. Recurrence of this disease leads to inflammation and scarring of the cornea and is a major cause of corneal blindness in the U.S. Diseases and injuries to this clear window of the eye account for 4 million cases of visual impairment and nearly one-fourth of all visits to physicians for medical eye care. More than 32,000 corneal transplants are performed each year, the vast majority of which are highly successful thanks to earlier advances in federally financed eye research. Nevertheless, graft rejection continues to be a problem for many patients. In the **COLLABORATIVE CORNEAL TRANSPLANTATION STUDY** (CCTS) six medical centers are investigating potential benefits of matching donors and high-risk recipients of corneal transplants. It may be possible in the long-term to circumvent the risk of rejection altogether. Scientists, with support from the Eye Institute, are making rapid progress in developing an artificial cornea that will "heal" into place with a surface layer of natural cells as a barrier against infection. This progress has been speeded by an efficient method to grow corneal cells also pioneered by investigators under a grant from the National Eye Institute.

Mr. Chairman, among the most pernicious of eye diseases is **GLAUCOMA**, elevated pressure in the eye that can damage the optic nerve. Two million citizens have been diagnosed with this disease, while another estimated one million have it but do not know it. Glaucoma is the leading cause of blindness in black Americans whose risk of the disease is up to ten times greater than it is for white Americans. Studies are underway in several communities to provide information on the prevalence of the disease and risk factors involved. In addition, eight medical institutions are participating in the **GLAUCOMA LASER TRIAL** (GLT) to determine the safety and long-term efficacy of laser therapy as compared to the standard use of eyedrops as the initial treatment. These studies will greatly increase our ability to identify and preserve the sight of persons with dangerously high intraocular pressure.

Critically important are studies of developmental processes that govern binocular vision and creation of a clear image on the retina of the eye. Up to four percent of America's children are affected by **EYE MOVEMENT DISORDERS** (strabismus), and each year more than 80,000 people with misalignment of the eyes undergo eye muscle surgery. Scientists recently determined that amblyopia (a dimness in sight without apparent changes in the structure of the eye), the major cause of blindness in children, is not a single disorder but a variety of deficits that differ among patients. A national collaborative study coordinated by members of the University of Iowa is underway to determine the most effective means of treating children and adults with certain types of strabismus. New camera techniques and preferential viewing devices are being developed for the widespread screening of infants and preverbal children for amblyopia and refractive errors to uncover these and other disorders at the earliest stages of human development. Early treatment and prevention can avert a lifetime of visual disability. Computer techniques for image enhancement developed in the U.S. Space Program for high altitude photography are being adapted to enable children and adults with extremely low vision to read and recognize faces.

We have made great leaps of progress in the preservation and restoration of sight over the past two decades even while the causes of visual loss have remained largely unknown. Today, rapid advances in science and technology are making possible unprecedented forays into the micro-world of the eye and the organisms that attack it. This basic research is greatly expanding our knowledge of fundamental processes and pointing the way, not only to new treatments for potentially blinding eye diseases, but to the first practical methods for their prevention.

MULTICENTER COLLABORATIVE CLINICAL TRIALS play a critical role in quickly turning this new knowledge into safe and effective treatments and preventives for use by practicing physicians and their patients. Complicated full-scale clinical trials are, for the most part, beyond the financial resources of individual departments of ophthalmology. The National Eye Institute provides the essential framework for collaboration between government and private institutions, including 86 medical institutions across the nation that are currently involved in NEI-sponsored trials.

To sustain this highly effective partnership and the rapid progress it has made in the fight to preserve the best possible vision for all Americans, it is extremely important that CONSTRUCTION FUNDS continue to be made available for eye research. There must be no delay while Congressional studies are in progress in meeting construction needs in other scientific areas. Many of our departments of ophthalmology and vision research institutes have long ago outgrown their limited and often antiquated facilities. A survey conducted in 1988 by Research to Prevent Blindness revealed that more than 80 departments of ophthalmology at these institutions need to double the amount of research space available to them by 1995, either through renovation or new construction. Their physical capacity for eye research must be increased by an estimated one million square feet at a projected cost of $300 million if they are to keep pace with technology and attract highly qualified scientists who will lead tomorrow's fight against blindness. We strongly recommend that Congress appropriate $10 million for eye research laboratory construction and renovation in the Fiscal Year 1990 budget of the National Eye Institute.

I urge this Committee to recommend approval of the proposed Citizens' National Eye Institute budget for Fiscal Year 1990. Our request contemplates expenditures in the following categorical program areas: for Retinal and Choroidal Diseases, $131,216,000; for Corneal Diseases, $40,732,000; for Cataract, $21,205,000; for Glaucoma, $25,830,000; and for Strabismus, Amblyopia and Visual Processing, $51,208,000. We also recommend an appropriation of $32,266,000 for Intramural Research, Management and Program Services, and an additional $10,000,000 for Extramural Laboratory Renovation, Construction and Instrumentation, for a total budget of $312,457,000.

In summary, Mr. Chairman, our Citizens' Committee Budget is based upon a national Vision Research Plan resulting from continuing evaluation and guidance of more than 350 leading scientists in all areas of vision research. Our recommendation is a reasonable assessment of the funds needed to grasp only the most promising of existing opportunities for productive investigation. It is imperative that sufficient funds be appropriated for continued intensive research and for the clinical trials which save this nation many times over the dollar amount invested. I earnestly request that this Committee recommend approval of the Citizens' Budget of $312,457,000 for the National Eye Institute for Fiscal Year 1990. Proposed expenditures in all categories are specified in the Financial Tables appended to my statement.

I sincerely appreciate the opportunity to present this testimony and shall be pleased to respond to any questions. Thank you.

BIOGRAPHY OF THOMAS A. WEINGEIST

THOMAS A. WEINGEIST, M.D., Ph.D., is Professor and Head of the Department of Ophthalmology at the University of Iowa in Iowa City; the Associate Secretary for Self-Assessment of the American Academy of Ophthalmology; Chairman of the Credentials Committee of The Macula Society; a member of The Retina Society; and has many other national and international professional affiliations. Dr. Weingeist is an editor of several books in ophthalmology, a member of the editorial board of the Journal of the American Academy of Ophthalmology, and author of more than 100 scientific papers, articles and reviews on vitreoretinal diseases and other eye disorders. A proponent of advanced computer applications in patient care, teaching, and research, Dr. Weingeist is a leader in the development of computerized photographic retrieval systems and computerized instruction programs in ophthalmology. His department serves as the national Photograph Reading Center for two multicenter clinical trials (the Collaborative Ocular Melanoma Study and the AIDS-Related Cytomegalovirus Retinitis Study) in which he is a principal investigator.

Attachment

NATIONAL EYE INSTITUTE FINANCING

	Fiscal Year 1989		Fiscal Year 1990	
	Appropriation	Comparable Estimate*	President's Budget Request*	Citizen's Budget
	(Dollars in Thousands)			
By Activity:				
Grants:				
Research Grants............	$181,171	$176,989	$183,222	$241,507
Laboratory Renovation, Construction and Instrumentation..........				10,000
Core and Specialized Center Grants...................	6,993	6,993	6,908	12,100
Individual Training........	1,475	1,475	1,525	3,391
Institutional Training.....	4,189	4,189	4,332	4,693
Total Grants..........	193,828	189,646	195,987	271,691
Direct Operations:				
Intramural Laboratory and Clinical Research........	20,248	19,692	21,016	21,516
Research and Development... Contracts................	7,006	7,006	6,935	8,500
Biometry, Epidemiology and Field Program............	1,550	1,550	1,600	1,700
Research Management and Program Services.........	8,598	8,570	8,239	9,050
Total Direct Operations..	37,402	36,818	37,790	40,766
Total NEI Obligations..	**$231,230**	**$226,464**	**$233,777**	**$312,457**

NATIONAL EYE INSTITUTE FINANCING

	Fiscal Year 1989		Fiscal Year 1990	
	Appropriation	Comparable Estimate*	President's Budget Request*	Citizen's Budget
	(Dollars in Thousands)			
By Program:				
Extramural Research:				
Retinal and Choroidal Diseases................	$95,958	$91,776	$94,648	$131,216
Corneal Diseases..........	30,741	30,741	31,710	40,732
Cataract..................	16,306	16,306	16,830	21,205
Glaucoma..................	18,589	18,589	19,247	25,830
Strabismus, Amblyopia, and Visual Processing.......	39,240	39,240	40,487	51,208
Extramural Laboratory Renovation, Construction and Instrumentation.....	--	--	--	10,000
Total Extramural Research............	200,834	196,652	202,922	280,191
Intramural Research:				
Laboratory and Clinical Research, Biometry and Epidemiology...........	21,798	21,242	22,616	23,216
Research Management and Program Services........	8,598	8,570	8,239	9,050
Total Intramural Research..............	30,396	29,812	30,855	32,266
Total NEI Obligations..	$231,230	$226,464	$233,777	$312,457

* The 1990 request and the comparable 1989 column exclude funds for AIDS research proposed for consolidation in the Office of the Assistant Secretary for Health in 1990.

Senator HARKIN. I have no questions, Dr. Weingeist. I am aware of the fine work that the University of Iowa does for the Eye Institute and we will do what we can to keep the budget up.

Dr. WEINGEIST. I appreciate that.

STATEMENT OF DICK SULLIVAN, CHAIRMAN, METROPOLITAN DIVISION, CANDLELIGHTERS

Senator HARKIN. Now we will go to Dr. John Ultmann, chairman, National Coalition for Cancer Research.

Mr. SULLIVAN. My name is Dick Sullivan. I appear here today as chairman of the Metropolitan Division of Candlelighters. It is a nationwide organization of some 30,000 parents of children with cancer.

I am not in that capacity. I appear here for Dr. Ultmann who as you know is chairman of the National Coalition for Cancer Research. Unfortunately, the doctor is being treated for prostate cancer in Chicago at this time. I have the privilege to represent him.

Let me be brief. The written testimony is before the committee, as I know. Let me summarize as briefly as I can. This coalition covers a broad spectrum across the board, Mr. Chairman. It goes from hospitals, research centers, nurses, doctors, down to individual patients and what the doctor is asking for is specifically the following: roughly the $8.4 billion figure. I know the budget problem you face, but this is the figure he is requesting.

We point out for the first time since we got through the 1971 act on cancer, the victory over cancer program, for the first time last year unfortunately due to Gramm-Rudman and the budget operation you had to reduce us some $200 million. The bypass budget of President Bush asks for $400 million for additional research money for cancer.

PREPARED STATEMENT

We are not going that high. We specifically ask for an additional $200 million to be used for clinical research, basic research and training and I thank you very much for your time.

[The statement follows:]

STATEMENT OF DR. JOHN E. ULTMANN

Mr. Chairman, distinguished Members of the Subcommittee, thank you for the opportunity to provide testimony before you today on behalf of the National Coalition for Cancer Research. I am Dr. John E. Ultmann, Professor of Medicine and Director of the Cancer Research Center at the University of Chicago. As a volunteer, I serve as the Chairman of the National Coalition for Cancer Research. With your permission, I ask that my full statement be included in the record and I will briefly highlight my testimony.

Before I address the purpose of my testimony before you today -- increased funding for our National Cancer Program -- I would like to introduce the National Coalition for Cancer Research (NCCR). The NCCR is made up of nearly every cancer research, cancer care and lay group in this country concerned with the fight against cancer. The coalition represents over 65,000 cancer researchers, nurses and physicians; 325 cancer hospitals, centers and clinics; 57 cancer research centers; 30,000 parents of children with cancers and the organization for cancer survivors -- those individuals who have directly benefited from the fruits of our research and the goodwill of the Congress in continuing to fund our National Cancer Program. We are the essence of a broad based coalition representing the -- researchers in the laboratory identifying the very clues which will eventually provide the very complex answers to the many questions which remain; physicians and nurses who daily care for persons with cancer and assist them in every way possible to remain productive and contributing members of our great society; and, last but most importantly the families and patients themselves whose struggle daily against a formidable opponent. On behalf of these individuals, I thank you for the opportunity to appear before you today.

Allow me also to take this opportunity to thank you for your excellent support of the our research efforts in years past. Many of us in the research community are keenly aware that if it were not for the interest of you and your colleagues, our National Cancer Program would be under greater duress than it already is. The research community knows about the difficult constraints that the Subcommittee is under. However, we must continue to knock at your door, so to speak, and build the case for increased funding for our National Cancer Program. I believe that the case is a strong one.

Last year, the National Cancer Institute was funded $20 million below the President's Budget Request. This was the first time that the NCI was appropriated less than the President's Budget requested. I realize that this was a result of across the board cuts which occurred subsequent to the Subcommittee's recommendations for funding, which were above the President's Request. However, the effects of this cut were detrimental to our cancer research initiatives and quite demoralizing to the research community.

This year, the Coalition supports the Ad Hoc Group for Medical Research request for 1990 of $8.416 billion for the National Institutes of Health (NIH), a $1.3 billion increase. Further, we recommend that the Subcommittee provide at between $170 - $200 million of these increased funds for the National Cancer Institute (NCI). While this appears to be a substantial increase for the NCI, funding at this level will still be approximately $380 million short of the 1990 "By-Pass" Budget request, statutorily required by the 1971 National Cancer Act and endorsed by the National Cancer Advisory Board. The funding level requested by the "By-Pass" Budget is a professional judgement budget which is based upon existing opportunities which exist in cancer research. The cancer community believes that the failure to fund these initiatives has, in fact, slowed our progress against this disease and we look to the Congress to give serious consideration to this budget request.

Additional funds for the NCI would be used to support the following initiatives.

BASIC RESEARCH

Under the 1990 President's Budget Request, the NCI would be able to fund 30% of the competing grants with a 10% downward negotiation. Funding above the 1990 President's Request for the NCI, would enable the institute to fund these grants at their recommended levels. In addition, it would provide funding to restore non-competing grants as well as an additional 178 competing awards, raising the percentage of approved grants funded to 37%.

It is important that we address the problems faced by research investigators in the support of their grants. Over the past several years, we have seen the percent of approved grants funded by the NCI drop from 36% in 1985 to a projected level of 30 in 1990.

Your continued support of the long term investment in basic research is the backbone of our progress toward curing diseases, such as cancer. We cannot overstate the intrinsic value of basic research. It is through basic research - aimed at understanding how the smallest unit of life, the cell, works - which promises to provide us with the knowledge of how to eradicate diseases such as cancer.

This past winter, the Washington Post ran a five day series entitled "Life Itself:Unraveling the Mysteries of Biology." I have provided a copy of this series for your review. In reading this series, I am proud to say that many, many of the scientific achievements identified in this article were a result of funding of basic research through the National Cancer Institute. In fact, I could not read any of the 26 pages of this series without coming across a number of research discoveries made possible through funding of basic research by the NCI. Your support of our research programs has contributed to both success and advances in our ability to enable us to sooner -- rather than later -- fulfill the mission of the National Cancer Program to conquer cancer.

I have outlined some significant accomplishments below.

Research supported by the NCI has

- **identified a special cell of the immune system, called the natural killer cell,** which is responsible for searching for and destroying cells which have become cancerous. This has enabled many researchers to step up their efforts and test new theories on the prevention and cause of cancer. Eventually, this will allow us to develop new approaches to the treatment of cancer.
- **identified the regulatory mechanisms for cells** which dictate when cells should and should not divide. This has enabled researchers to understand the process of unregulated cell division and its role in allowing cells to become cancerous.
- **demonstrated that 5,000 women a year** with breast cancer that has not spread to underarm lymph nodes can benefit from receiving chemotherapy or hormonal therapy after surgery.
- **innovative adjuvant therapy which combine chemotherapy with radiation therapy** has had very promising results for persons with colo-rectal cancers, osteosarcomas, pediatric and soft tissue sarcomas.
- **radiation therapy combined with chemotherapy** has produced a four-year survival rate of nearly 60% of certain lung cancers, as compared with the 10 - 20% with previous therapies.
- **enabled dramatic life saving therapy for the treatment of testicular cancer in young men** which has lead to reduced

health care costs and preserved earnings of men who return to full employment, amounting to an annual savings of about $145 million.

- **developed the prototype of two new diagnostic tests**, one for bladder cancer and one for lung cancer which will enable the early diagnosis at a more treatable stage of these forms of cancer.

CLINICAL RESEARCH

Additional funds for the **Cancer Centers Program** and **Cooperative Clinical Research** would be provided under our recommendations. This would **enable the NCI to fully fund and maintain a level of 60 centers.** As you may know, five cancer centers may be eliminated in FY 1989 and another five may be phased out in FY 1990 as a result of funding constraints. Further, an **increase in patient accrual into group clinical trials** would be possible with increased funding and would **enable important initiatives, such as access of minority populations and expansion of efforts involving biologic response modifiers.**

In this connection, I would like to draw your attention to a report of a committee of the INSTITUTE OF MEDICINE, chartered at the request of the Senate Appropriations Committee, to be published next week. Entitled a STRONGER CANCER CENTERS PROGRAM, the committee recommends that the Director of the NCI take immediate steps to avert a crisis in the funding of the program during the current fiscal year (1989). The committee recommends further that the Directors, NCI and NIH, with the Secretary of the Department of Health and Human Services, work with the appropriate committees of the Congress to develop an adequate budget for the program's next fiscal year (1990). Otherwise, the committee is concerned that projected funding levels for the core grant program this year and next will result in the loss of centers with excellent peer-review priority scores before the program planning process is completed.

In addition, the committee recommended that the Director, NCI

- allocate the additional funding needed to fund at 85 percent of recommended levels the core grants of the competing centers that have fundable priority scores, up to a limit of $6 million, for FY 89;
- for fiscal year 1990, the Administration and the Congress develop a budget that will avoid the current situation and continue to provide support grants to those competing centers that have excellent programs, as measured by peer-review priority scores;
- consider best how to increase representation of the cancer centers program in NCI planning and decision-making processes, including regular representation of the centers at the NCI Executive Committee meetings and the creation of an external advisory committee to review the multidisciplinary programs;
- and, that the management capabilities of the cancer centers program unit be substantially strengthened to plan, monitor, evaluate and implement cancer centers programs.

TRAINING

The federal deficit has had a tremendous impact in many areas of our economy and on our ability to compete in foreign markets. Similarly, cuts in training have had a tremendous impact on our ability to maintain a pool of young and talented scientific investigators to meet the needs of our research enterprise. While I have been able to fill the research positions within my medical center, the day when I will not be able to -- because of a lack of trained investigators -- is rapidly approaching.

The training of biomedical scientists is a long term undertaking requiring a minimum of 8 to 10 years after baccalaureate education. Because of this long lead time, provisions are needed now to make sure that trained experts will be available in the short term as well as the long term. Training skilled investigators to deal with the complexity of cancer research can not be done with the ease of turning on and off a water faucet.

The cancer research community is dismayed at the cuts in the number of trainees recently implemented by the NIH as a result of increasing stipends without a complimentary increase in funds. We look to you for support in restoring the 1988 levels for training in FY 1989 and 1990, as well as expanding Cancer Education Programs. We anticipate that the education programs will have an emphasis on minorities in biomedical research to meet the acute needs which are evolving in this area.

In addition, funding at our requested level would allow the NCI to provide funds for the following.

* The **Supercomputer** capacity and facilities for the NCI, NIH and extramural medical research community to provide enhanced capacity to design anti-cancer and anti-AIDS drugs.

* **Cancer Prevention and Control** programs to increase efforts into minority populations.

* **Construction and maintenance** to address the deteriorating physical plant at the Frederick Cancer Research Facility.

* **R&D Contracts** to meet the needs of NCI's drug development, chemical carcinogenesis and epidemiologic programs.

* Expansion of **Cancer Information Systems** to fully disseminate the latest findings in cancer care to the general public and to the medical community. As you may know, new authorities were added to the National Cancer Act last November.

* Studies to further elucidate the significant problems of **cancer in minority populations and persons over the age of 65.** It is apparent that these two groups experience a disproportionate rate of cancer mortality and we need to mount aggressive efforts to respond to this data.

While it sounds like quite a shopping list and a hefty price tag, we need to obtain funding for these programs if we are to meet the emerging needs of our National Cancer Program. Since the National Cancer Act was passed, we have come a long way. We have made great strides in the treatment of childhood leukemia, breast cancer, Hodgkin's disease, lymphomas and many other disease. In addition, we have laid the foundation of knowledge from which evolve all the future treatments as well as our ability to eradicate cancer. That in and of itself is remarkable.

As I said last year, I am aware of this Subcommittee's responsibility to this Nation to be fiscally responsible. I, as a physician and researcher also have a responsibility -- to expand our cancer research efforts until we have all the answers. Personally, I shall not stop until I no longer have to go on rounds within my cancer center and look patients in the eye and tell them that I am sorry, there is nothing more that can help them in their personal fight against cancer. Mr. Chairman, I hope to see the day when the priorities of this Nation allow you to help me, and my colleagues, to the extent necessary, to meet the needs of our National Cancer Program. Until such time, I hope that you will think kindly of the Coalition's request and provide funding for the programs I have outlined.

This concludes my formal remarks. I will be happy to answer any questions that you may have.

Senator HARKIN. $200 million over and above the bypass?

Mr. SULLIVAN. Over and above.

Senator HARKIN. Over and above the President's budget?

Mr. SULLIVAN. That's correct, sir.

Senator HARKIN. Not the professional bypass budget. All right, Mr. Sullivan. Thank you very much for being here. I appreciate it. It is good to see you again. You know, I used to be on the House side over there when you ran the place.

Mr. SULLIVAN. They have not caught up with me yet, Mr. Chairman. I am still over there.

Senator HARKIN. I am glad to see you.

Mr. SULLIVAN. Delighted to see you again, sir. Thank you very much.

Senator HARKIN. Thank you very much.

STATEMENT OF DR. WARREN K. ASHE, AMERICAN HEART ASSOCIATION

Senator HARKIN. Next, Dr. Warren Ashe, the American Heart Association.

Dr. ASHE. Mr. Chairman and members of the committee, I am Warren K. Ashe, assistant dean for research at the Howard University College of Medicine and immediate past-chairman of the board of directors of the American Heart Association's Nation's Capital Affiliate. It is my pleasure to present the AHA's comments and funding recommendation for the National Heart, Lung and Blood Institute this morning.

Cardiovascular diseases and stroke remain the Nation's leading cause of death, claiming about 1 million lives each year. In 1989 alone, we estimated the cost associated with these diseases would be approximately $88.2 billion in medical expenses and lost productivity of human lives.

While the AHA continues to commit a larger portion of its resources to research, adequate Federal funding for biomedical research is critical to continue the progress in the fight against cardiovascular diseases and stroke.

The AHA applauds the subcommittee's support during the fiscal year 1989 appropriations process, for funding NHLBI's new laboratory of cardiac energetics and funding the $3.3 million increase in the institute's budget to purchase and install a state-of-the-art magnetic resonance imaging device.

This subcommittee has made it possible for the laboratory to use human subjects in these studies, which is a noninvasive procedure. The administration's fiscal year 1990 budget for the NHLBI is $1.083 billion, including AIDS support. This programmatic impact of this budget would stifle the NHLBI's research efforts.

The troubling aspects of the administration's proposal include the following: There would occur a drop in the number of competing and research project grants to the lowest level since 1980; a decrease in funds for the same number of centers, creating a projected 16- to 17-percent reduction from such recommended levels, thus adversely affecting cardiovascular centers; the same number of research degree program awards and research training positions at less than sufficient funds to cover the expected rate of inflation for biomedical research.

There would occur a reduction in funds for research and development contracts, causing the postponement of all new planned clinical trials, including priority ones in the cardiovascular area.

Finally, there would occur a cut in funds for the research management and support mechanism, thus reducing money available for educational programs by approximately one-half.

The NHLBI's program arsenal has been highly effective in the battle against cardiovascular diseases and stroke. Although a high priority is given to the funding for research project grants, the Institute also stresses other program mechanisms such as clinical trials, population studies, specialized centers of research—that is, core centers—national research and demonstration centers, research, career and training awards, research and development contracts and education, directed-mission programs.

PREPARED STATEMENT

This carefully balanced approach has contributed to the success of the Institute's programs and has enhanced the Institute's reputation as a worldwide leader in cardiovascular research. Based on a careful review of the Institute's critical needs, the American Heart Association recommends a fiscal year 1990 appropriation of $1.239 billion for NHLBI, which represents an 18.5-percent increase over its fiscal year 1989 level.

Mr. Chairman, I thank you for the opportunity to present this testimony on behalf of the NHLBI and the American Heart Association.

[The statement follows:]

STATEMENT DR. WARREN K. ASHE

I am Warren Ashe, Assistant Dean for Research at the Howard University College of Medicine and Immediate Past Chairman of the Board of the American Heart Association's (AHA) Nation's Capital Affiliate. It is my pleasure to present the AHA's comments and funding recommendations for the National Heart, Lung, and Blood Institute (NHLBI).

The AHA is dedicated to the reduction of premature death and disability from cardiovascular diseases and stroke. Since 1948, the AHA and the NHLBI have been active partners in the battle against these diseases. The research, training, education, and community service programs of both the AHA and the NHLBI have had a significant impact on the diseases of the heart and circulatory system.

Cardiovascular diseases and stroke remain this Nation's leading cause of death, claiming about one million lives a year. In 1989, we estimate the cost associated with these diseases will be $88.2 billion in medical expenses and lost productivity. However, progress is being made. From 1976 to 1986 the age-adjusted death rate from heart attack fell by 27.9 percent and that from stroke fell by 40.2 percent. But, there is still a long way to go. More than one in four Americans suffer some form of these diseases.

The AHA's ability to combat cardiovascular disease correlates directly with the level and quality of overall support of basic and clinical research and prevention efforts. Adequate funding of Federal biomedical research is critical.

The NHLBI's program arsenal has been highly effective in the battle against cardiovascular diseases. Although a high priority is given to the funding for research project grants, the NHLBI also stresses other program mechanisms such as clinical trials, population studies, specialized centers of research (SCOR), national research and demonstration centers, research career and training awards, research and development contracts, and education and direct prevention programs. This carefully balanced approach has contributed to the success of the Institute's programs and has enhanced NHLBI's reputation as a world-wide leader in cardiovascular research.

First, I will focus on the NHLBI's current budget. The AHA applauds this Subcommittee's support for the NHLBI's new Laboratory of Cardiac Energetics. In funding the $3.3 million increase for the NHLBI to purchase and install a state-of-the-art magnetic resonance imaging device, this Subcommittee has made it possible for the Laboratory to use human subjects in these non-invasive studies. The data from this program will lead to further advances in the prevention, diagnosis, and treatment of cardiovascular diseases.

However, an overriding concern is that the NHLBI has not received sufficient funding to meet critical needs. Because research areas under the NHLBI umbrella include most of the leading causes of death in this Nation, we believe that the allocation of funds among the NIH institutes should reflect this important fact. Under the Administration's FY 1990 request, the NHLBI is near the bottom in proposed percentage increases.

A continuing concern is the rising average cost of research project grants. This increase includes higher cost for equipment, personnel, and patient care. Because the Institute sponsors extensive clinical research, these costs cannot be avoided. In FY 1989, the discrepancy between the NHLBI's estimated average cost of grants and the actual average cost has required a 10 percent cut in individual competing research grant awards.

Now, I will turn to the FY 1990 budget. All numbers and dollar figures in our recommended funding levels include AIDS money. The Administration's FY 1990 budget includes $1.083 billion for the NHLBI. This 3.5 percent increase over the FY 1989 appropriation does not support adequate growth. If this budget were enacted, it would severely restrict the NHLBI's ability to begin exciting new research, to expand existing programs to more adequate levels, and to support the recently broadened circulatory assist/artificial heart program. Troubling aspects in the Administration's budget follow.

- o A drop in the number of competing research project grants to the lowest number since 1980.
- o A decrease in funds for the same number of centers.
- o The same number of research career program awards and research training positions at less than sufficient funds to cover inflation.
- o A reduction in funds for research and development contracts, causing the postponement of all planned new clinical trials.
- o A cut in funds for research management and support mechanism, reducing money available for educational programs by approximately half.

Under the Administration's FY 1990 budget, the NHLBI could only award 601 competing research project grants, compared to an estimated 646 in FY 1989. This represents a continuation of the decline in the number of such grants awarded over the past three fiscal years (966 in FY 1987 and 851 in FY 1988). Due to the growth in the cost of both competing and noncompeting research project grants, in FY 1990, approved grants will have to be cut by 11 percent and 13 percent, respectively. The AHA recommended funding level for the NHLBI will allow the Institute to restore these drastic cuts and support the grants at the approved study section level. Our recommendation will also allow the NHLBI to fund about 33.3 percent of approved competing research project grant applications, compared to the 21 percent rate proposed in the Administration's budget. In part, the AHA recommended funding level will allow the NHLBI to expand its Programs of Excellence in Molecular Biology and to begin initiatives on molecular genetics of hypertension and of atherosclerosis, two leading cardiovascular disease risk factors. The

NHLBI's Programs of Excellence in Molecular Biology complement the work of the AHA-Bugher Foundation Centers for Molecular Biology.

Specialized Centers of Research (SCOR) programs concentrate resources, facilities, and research personnel on high priority research areas. These centers are unique in their ability to combine basic science and clinical research in rapid translation of important findings into clinical applications. Although the Administration's budget calls for the same number of centers to be funded, it proposes a 1.18 percent reduction in funds. While Congress encourages new center programs, despite inflation and increasing costs of research, often no new funds are allocated to support these important programs.

In FY 1990, a $16 million increase is needed, in part, for the NHLBI to continue funding new center programs and to renew, restructure, and broaden, based on the recommendations of the Cardiology Advisory Committee and the NHLBI Advisory Council, the ischemic heart disease (IHD) centers to encompass coronary and vascular diseases, heart failure, and congenital heart disease. The IHD centers programs have made a major contribution in the declining mortality rate of hospitalized heart attack victims. Also, these programs have played a prominent role in drawing attention to the value of thrombolytic therapy for heart attack. Moreover, the IHD centers programs have had a significant impact on the mortality rate from sudden coronary death through progress in treating ischemic heart disease victims and through the initial clinical testing of the automatic implantable defibrillator.

Without a $16 million increase, the Institute's research centers programs will have to be severely curtailed. A 16 to 17 percent reduction from study section recommended levels is projected. This estimated decline in centers programs activities would prevent the NHLBI from sustaining its effort in ischemic heart disease and from expanding into the aforementioned needed areas of research. Moreover, if funds for centers are not increased, the NHLBI's other cardiovascular centers in the areas of atherosclerosis and in hypertension would be adversely affected.

Also, under the Administration's budget, research career programs and research training will each receive only a 3.4 percent increase over the FY 1989 level for the same number of awards and positions, respectively. This recommended funding level is less than sufficient to cover the estimated rate of inflation for biomedical research. Research career series awards, such as the NHLBI Preventive Cardiology Academic Award, provide researchers with specialized experience necessary to become independent investigators. A $2 million increase for research career series programs will allow the NHLBI to maintain its competitiveness in this area by conferring 27 additional awards for a total of 437. Moreover, a $3.3 million increase for the training mechanism will allow the Institute to increase the number of full-time training positions from 1,481 to 1,600, the minimum number needed to ensure an adequate number of highly trained investigators. This number represents 119 more than the number supported by the Administration's budget but 55 less than supported in FY 1988. The AHA recommended funding addition will cover the NIH increased stipend. The stipend increase, the first since FY 1985, has been instituted in an effort to attract more promising trainees. All training grants are awarded in five year increments. A relatively low proportion of these training programs compete for funds in FY 1989, but in FY 1990, a relatively high proportion will compete.

Moreover, the Administration's budget proposes a 1.07 percent decrease in the Institute's research and development contract mechanism. The AHA recommends a $19 million increase for this mechanism. If contracts were funded at the level requested by the Administration, no new clinical trials could be initiated and the Institute would be forced to continue reprogramming funds to support both artificial heart programs, the development of the biventricular assist device (artificial heart) and the clinical trial of the left ventricular device. An additional $4.1 million, included in the AHA recommended $19 million increase for contracts, is required to support both artificial heart programs. To meet 1988 Congressional intent for the continuation of the development of the artificial heart, the NHLBI had to reprogram funds. Also, the AHA recommended increase for the research and development contract mechanism will allow the NHLBI to initiate its highest priority clinical trials, including the following in the cardiovascular area:

- o assessment of intravenous thrombolytic therapy in dissolving blood clots to prevent heart attacks in unstable coronary heart disease victims,
- o evaluation of transfusion therapy in preventing additional strokes in sickle cell disease victims,
- o appraisal of antiarrhythmics and beta blockers to treat patients with irregular heart beats in the presence and in the absence of cardiac failure.

Funds under the research management and support mechanism are used to manage the Institute, to support the Framingham Heart Study, the Honolulu Heart Program, and the educational programs in risk factor reduction. The NHLBI's National High Blood Pressure Education Program and its National Cholesterol Education Program are prime examples of successful public and private cooperative efforts. They complement two of AHA's educational initiatives, the Heart Rx program and the Physicians' Cholesterol Education Program. The Administration's proposed 3 percent reduction in the NHLBI's research management and support mechanism would cut funds available for educational programs by approximately half. The funding reduction would also force the Institute to postpone several planned new major educational programs, including one designed to reduce the time which elapses between the onset of a heart attack and the admission of the victim to an intensive care unit. An additional $7 million for this budget category will adequately support the existing programs and allow the NHLBI to initiate planned new programs.

The AHA supports the NHLBI's efforts to launch a program to help physicians educate patients about warning signals and symptoms of heart attack and to help patients develop suitable emergency plans if they experience prolonged chest pains. When a heart attack occurs, it is critical to recognize the signals and respond immediately. Most heart attack victims who die do so within two hours from the time signals begin; consequently, time is critical. More than 300,000 people a year die of heart attack before they reach a hospital; therefore, a major educational effort is crucial. Studies show that 50 percent of heart attack victims wait more than two hours before going to an emergency room. Prompt care of these victims dramatically reduces heart damage. The AHA views an educational effort in this area as a high priority and is working to produce an effective program.

Based on a review of the NHLBI's critical needs, in part, highlighted above; we recommend a FY 1990 appropriation of $1.239 billion, an 18.5 percent increase over its FY 1989 level. This percentage increase is consistent with the Ad Hoc Group For Medical Research Funding's suggested increase for the entire National Institutes of Health (NIH).

We support the Ad Hoc Group For Medical Research Funding's recommendation of $8.416 billion for the NIH which would provide for a modest growth over current services.

Thank you, Mr. Chairman.

Senator HARKIN. Thank you very much, Dr. Ashe. It is an 18-percent increase?

Dr. ASHE. An 18.5-percent increase, yes, sir.

Senator HARKIN. Thank you very much, Dr. Ashe. We appreciate you being here.

STATEMENT OF SUSAN TOLCHIN, CYSTIC FIBROSIS FOUNDATION

Senator HARKIN. Next, we have Dr. Susan Tolchin.

Dr. TOLCHIN. I am representing Mr. Robert Dresing from the Cystic Fibrosis Foundation. How are you, Senator?

Senator HARKIN. I do not know you in this capacity.

Dr. TOLCHIN. We know each other in another capacity. I wear another hat. I do not know if you recall, but I recall very well testifying before you last year on behalf of the Cystic Fibrosis Foundation.

I am a professor of public administration of George Washington University and a board member of the National Cystic Fibrosis Foundation. Accompanying me here today is Suzanne Pattie, the consumer affairs coordinator of the foundation.

My son, Charles, who is now 20 years old, has cystic fibrosis and that is the reason I became interested in the activities of this foundation. This disease—he is 20 years old. When he was diagnosed the life expectancy of children with cystic fibrosis was 8 years old and now it is 21 and there are many adults who live in their thirties and forties and we hope that we can put this disease out of business so that our children and other cystic fibrosis adults will live into ripe old age.

Cystic fibrosis is the No. 1 genetic disease and killer of Caucasian children and as such deserves a high priority in our Nation's priority list. We are now very hopeful about the research which has been going on. We are coming very close to identifying the gene.

Researchers said, 4 years ago, that identifying the gene was hopeless and now we are very close. We have narrowed the search. The gene we know is on chromosome 7 and each year we come very close. This year alone we have gone down to hundreds of thousands of base pairs and we are very close to identifying the gene, which will mean new treatments and a diminution of the pain and suffering of people who have this disease.

I am here to thank Congress for your support. Last year you gave us $4 million for cystic fibrosis research centers and we are going up to $6 million specifically for cystic fibrosis research this year and we have already seen results from this Federal sponsorship of cystic fibrosis research.

We have a new drug that has been tested called amiloride, which has already been demonstrated to improve the pulmonary function of people who have cystic fibrosis and we are hoping that FDA tests will put this on the market very soon, but it shows that the Federal investment is already paying off and the short period of time that you have begun specifically funding CF centers, that investment is paying off.

The research center network, which is funded by NIH, continues to be the focus of scientific excitement. We have had five centers currently funded with NIH support and we are going to have two more, hopefully, if this funding comes through.

The Cystic Fibrosis Foundation is a perfect example of how the public-private partnership works. The foundation itself spends $25 million annually on research and we hope to raise that figure. We have gone up 44 percent since fiscal year 1989, so we know that joint ventures work. They work in business and they work with regard to the public-private partnership with medical research and the Government.

We are also concerned about the low award rate for NIH approved research projects across the board. We know that this affects U.S. competitiveness, which I know, Senator Harkin, you have been involved in, and other issues as well. We know that it discourages young scientists from entering the research field and it is particularly urgent for us in the cystic fibrosis business.

We support the ad hoc committee for medical research's recommendation of $8.4 billion for NIH to ensure our Nation's research lead.

Research has an urgency to us that it might not have to many other people in this society. It means the improvement of the quality of life and it means life itself and we also know that, from the point of view of Congress, not curing these diseases has a very high cost. The cost of cystic fibrosis for all the patients involved is $300 million a year. That is a very high cost in terms of dollars as well as in terms of suffering.

PREPARED STATEMENT OF ROBERT K. DRESING

We at the Cystic Fibrosis Foundation are one of the only organizations in this town that fervently hopes to go out of business. We are praying for our own sunset, because if we close up shop it means the disease goes out of business and with your help, Senator, and the help of the Federal Government, we hope that will be a reality.

Thank you very much. I will be happy to answer questions.

[The statement follows:]

STATEMENT OF ROBERT K. DRESING

My name is Robert K. Dresing and I am president of the Cystic Fibrosis Foundation (CFF). I come before you on behalf of the thousands of children and young adults with cystic fibrosis (CF), including my own 22-year-old son, Rob.

Those of us whose lives are affected by this fatal, genetic disease are entering the 1990's with optimism. The news from scientists is good: CF research is moving rapidly toward the knowledge that will allow our children to survive into the next century.

I thank you for your role in these advances, particularly your support of our research centers through your appropriations during the past two years. I am pleased to tell you that all six of our twelve research centers which applied for support initially were funded by the National Institute of Diabetes and Digestive and Kidney Diseases, and the National Heart, Lung and Blood Institute, and that our other centers are being reviewed right now.

We are committed to the public-private partnership of research funding that these centers represent. Joint ventures work in the business world, and they work in medical research as well. However, several areas of concern still exist. I would like to share with you how the Cystic Fibrosis Foundation is addressing these issues and ask for your partnership in these efforts.

Our fundamental concern is the lack of funds available for proven NIH programs, as evidenced by the low award rate for NIH-approved research projects. With only 20-25 percent of approved projects receiving funding, the sheer number of unfunded projects is threatening the morale of investigators and the stability of our nation's research programs.

The Foundation has attempted to pick up some of the slack by creating the CFF/NIH Research Award -- to our knowledge, the first award of its kind. The program provides up to two years of CFF funding for outstanding NIH-approved projects while scientists conduct additional research and resubmit even more competitive applications to the NIH. The response to this program has been dramatic; we now anticipate it will cost the Foundation more than one million dollars in just the first year.

While this is a large commitment of our dollars, it only begins to address the national problem. Our nation's scientists are no longer encouraging either their students or their children to go into academic medicine; in one researcher's words, science has become too uncertain a career. Many scientific areas are changing too rapidly to have major projects sitting unfunded indefinitely.

If the current high producers are becoming disillusioned, what will happen to the next generation of scientists? We are greatly concerned about adequate basic and clinical training programs. As we stand on the edge of a new era in CF research, when we must make the leap from the laboratory bench to the bedside, the availability of the best-prepared manpower is tantamount.

Through our own new physician-scientist award, the Foundation is making commitments of up to six years per grantee, representing $300,000 per person. From their residency to their first academic appointment, these people can concentrate on honing their research skills rather than worrying about their next source of support.

Our concern also extends to the support of the NIH's Intramural Program because many of our greatest leaders in CF began their careers at the NIH. This unique resource -- the only program of its kind in the world -- has suffered in recent years from inadequate funding and insufficient FTE positions. We have tried to help by expanding our CFF/NIH Fellowship Program. Eight NIH fellows are now being supported by the Foundation, and we've provided new sabbatical funding as well. While the NIH benefits from the brightest new talent, we benefit from the exemplary training these new physicians can bring to bear on CF.

We learned long ago that the federal government cannot and should not be responsible for meeting every research need, but these proven programs deserve your support. The Ad Hoc Group for Medical Research's recommendations of $8.4 billion for the NIH, with increased funds for research training, are critical to ensuring the well-being of our nation's research programs. There is always a demand for a quick fix, but advances in science repeatedly come from our long-term investment in well-supported mechanisms.

Another component of a strong national research program is research centers. Our commitment to creating our own centers entirely with private donations -- more than $22 million to date -- has more than paid for itself. Your appropriations in the last two years have shown that you recognize their importance. Now, however, these research centers face downward negotiations of an estimated 20-25 percent that threaten the very fiber of their work.

When we first developed the research centers based on your congressionally mandated report, we discovered that they more than justified their funding levels. One, they created an incredible sense of continuity. We no longer had to stop after every project was finished and ask, "What do we do now, and who do we get to do it?" We also began to get quick answers to the question, "How can other scientists benefit from this work?" because the other scientists were already applying the results in their labs next door. For example, at the University of North Carolina (UNC), basic researchers made landmark discoveries of abnormal ion transport in CF cells. These findings were immediately explored for clinical applications by other UNC scientists. The result: we are now completing the first clinical trial ever designed to offset the problems of the CF basic defect in the lungs.

When you're talking to an adult with cystic fibrosis who may only have several more years to live, the efficiency and productivity of research centers may mean the difference between being one of the last who died to being one of the first who survived. And when you're talking about a country whose health care costs have reached the astronomical level of $500 billion for one year, research centers offer one of the most promising ways to bring those costs down. For CF alone, the centers offer the chance to eliminate the more than $300 million this disease costs each year.

Indeed, the high cost of health care underscores a more basic issue: we must invest every penny that we can in research today. Yet this country currently is investing only a meager three-tenths of one percent of its GNP into the biomedical research that can bring these costs under control.

For our part, the Foundation has more than tripled our investment in CF research over the last five years. We continue to be in constant contact with the NIH, asking what we can do to help support a conference or start a new funding program. But there are things we cannot do, and it is for those that we come to you, to ask you to continue and to strengthen your investment in our research centers and the NIH's programs.

Only one-half of one percent of the NIH's budget goes directly to support cystic fibrosis research. We ask you to make sure that this money is invested where it can bring the greatest and speediest return: our children's lives.

Senator HARKIN. Dr. Tolchin, thank you very much. I have figures from NIH that we have $35.1 million this year and this goes to $36.3 million for cystic fibrosis.

Dr. TOLCHIN. Yes; that is including the intramural projects. We specifically—the $4 million and the $6 million figures are specifically for the centers, but there is also a great deal of research going on intramurally at NIH for cystic fibrosis research and we are very grateful for that. It is important.

Senator HARKIN. Thank you very much.

STATEMENT OF ALFRED MUNZER, M.D., AMERICAN LUNG ASSOCIATION/ AMERICAN THORACIC SOCIETY

Senator **Harkin**. Now, Dr. Alfred Munzer of the American Lung Association and the American Thoracic Society.

Dr. **Munzer**. Mr. Chairman, and member of the subcommittee, the American Lung Association, and the American Thoracic Society, the association's medical arm, thank you for this opportunity to comment on the health and biomedical research programs for the fiscal year 1990 budget.

I am Dr. Alfred Munzer, director of critical care at Washington Adventist Hospital, and in the active practice of pulmonary medicine, and, therefore, one witness to the suffering of millions of Americans who have such lung diseases as chronic bronchitis, asthmas, emphysema, and lung cancer.

To these patients and millions of Americans at risk of lung disease, the research conducted by the institutes that are a part of our formal written testimony are the last, best hope for leading longer and more productive lives.

To fund these institutes below the figures we have suggested is to deny them relief from incredible pain and suffering.

We are concerned about the erosion of project grants, the keystone of NHLBI research programs. Each year, the actual cost of an NHLBI grant has been higher than the cost appropriated by Congress to support the new and competing projects; a downward negotiation results.

And in the President's budget, this would require an 11-percent reduction from the recommended level for noncompeting grants, and a 13-percent reduction for competing grants.

Over and above this downward negotiation, the President's budget proposes to reduce the number of competing grants to be awarded. An additional $37 million would decrease these reductions to approximately 10 percent, and permit funding, furthermore, of 45 more grants, the fiscal year 1989 funding level.

The NHLBI supports 66 specialized centers of research. We are concerned that the funds appropriated for these centers do not include any funds for two disorders, which the centers have now been mandated to investigate: sleep disorders and cystic fibrosis.

An additional $60 million is needed to provide adequate resources for the specialized centers of research.

Tuberculosis does not make the headlines, but it continues to be a major problem. The administration has proposed in its budget that Federal funding for tuberculosis control activities be included in the preventive health services block grant rather than through the current project grant system.

That, however, is a very poor mechanism for providing support for the control of an infectious disease such as tuberculosis, which is transmitted without regard to State boundaries.

PREPARED STATEMENT

The project grant mechanism ensures that there is a coordinated interstate approach to the control of tuberculosis. We recommend rejection of the administration's proposal and urge the subcommittee to appropriate the fully authorized level of $36 million for tuberculosis project grants.

Thank you very much.

[The statement follows:]

STATEMENT DR. ALFRED MUNZER

Mr. Chairman and Members of the Subcommittee, the American Lung Association and the American Thoracic Society, ALA's medical section, thank you for this opportunity to comment on the health and biomedical research programs in the FY 90 budget. I am Dr. Alfred Munzer, Director of Critical Care at Washington Adventist Hospital and in the active practice of pulmonary medicine.

The ALA/ATS has reviewed the lung related research, training, and demonstration programs for the National Heart, Lung and Blood Institute as well as for other institutes and agencies conducting activities related to the prevention and control of lung disease. The recommendations we are making today represent our best estimate of the adequate resources necessary to continue these programs at the level of priority funding indicated by the magnitude of the lung disease problem--which cost the U.S. a staggering $44.6 billion in 1987. The funding levels include recommendations for AIDS activity, as appropriate.

SUMMARY: FY 90 HEALTH APPROPRIATIONS RECOMMENDATIONS

National Heart, Lung and Blood Institute	$1,203.0 M
National Institute of Allergy and Infectious Diseases	856.8 M
National Institute of Environmental Health Sciences	256.9 M
National Institute for Occupational Safety and Health (CDC)	81.0 M
Tuberculosis Project Grants (CDC)	36.0 M
Office on Smoking and Health (CDC)	5.0 M
Office of Health Promotion (CDC)	5.0 M

THE NATIONAL HEART, LUNG AND BLOOD INSTITUTE

The National Institutes of Health represent the largest source of funding for lung related research in the U.S. This research program--principally within the National Heart, Lung and Blood Institute--has contributed significantly to the remarkable progress made in the past decade toward unmasking the basic biological preventive strategies for these diseases. The NHLBI research portfolio includes several research mechanisms of importance to lung related research.

The **Project Grant** continues to be the keystone of the NHLBI research program. An exciting new area of research for the Institute involves investigation utilizing new technologies in molecular biology.

A major problem in the management of the Projects mechanism relates to the average cost of a grant. Each year the average cost of an NHLBI grant has increased more than the estimated average cost appropriated by Congress to support the new and competing research projects. In FY 78 the cost was $89,000 per grant increasing to $245,000 per competing grant in FY 89. This increase is due, in large part, to the proportion of clinical research sponsored by NHLBI, which has higher costs due to patient care, personnel, and equipment needs.

A "downward negotiation" is required to offset this difference. The President's budget proposal would require an 11% reduction from the recommended level for noncompeting grants and a 13% reduction from competing grants. The difference between the estimated average cost and the actual cost has significant impact on the integrity of the research program. A further downward negotiation increases the severity of the impact.

Over and above the "downward negotiation" mechanism, the President's budget proposes to reduce the number of competing grants to be awarded. **An additional $37 million would reduce the reductions to approximately 10% and permit funding of 45 more grants--the FY 89 funding level.**

The NHLBI supports 66 **Specialized Centers of Research** -- SCORs. The SCOR program is a unique research mechanism that emphasizes both basic and clinical research to ensure that advances in the basic sciences are quickly translated into applications at the clinical level. This research mechanism directly benefits patient and public health. Several SCOR programs are managed by the Division of Lung Diseases (DLD). Funding for future year costs of the newest programs--Sleep Disorders and Cystic Fibrosis--has not been provided since the Institute was given the mandate for these new programs in FY 88. This is of particular concern since the President's budget proposal for this mechanism is lower than the FY 89 current services estimate.

An additional $16 million is needed to provide adequate resources for the SCOR program throughout the NHLBI including new initiatives in the Heart and Blood programs.

The NHLBI supports a number of Clinical Trials through the **Research Contracts** mechanism. A major trial--The Lung Health Study--has been initiated to study chronic obstructive pulmonary disease (COPD). This trial represents an 8-year obligation by the Institute to determine if those individuals considered at risk for the development of COPD can avoid it through a series of intervention strategies, including the use of certain bronchodilator medications. The findings of this trial are critical to improving the treatment of the 10 million persons with COPD in the United States.

The Institute's **Public Education** and direct prevention initiatives are funded from two mechanisms that have no flexibility -- research contracts and research management and support. The NHLBI has begun administering and coordinating a National Asthma Program as a follow-up to its successful Asthma Self-Management Program. An expanded program is proposed to distribute asthma education programs to health care professionals for their use in teaching sub-management to patients. **An additional $7 million is necessary to provide for this new initiative as well as other education initiatives already underway.**

A continuing problem for the NHLBI is the growing imbalance in the research program. The distribution of funds among the research mechanisms has markedly changed in recent years impacting the ability of the Institute to maintain a balanced program. The percentage increase of funds to Research Projects has been made at the expense of other research mechanisms. While the funding of research projects is an important component of the NHLBI program, support for other research mechanisms must be maintained to achieve program balance.

A final issue with direct impact on the NHLBI research program is the lack of flexibility in program management. Congress should continue to require OMB to apportion funds appropriated to the NIH at the individual institute appropriated level. Such action can restore flexibility to program management and allow institute directors to take timely advantage of new and emerging research opportunities.

THE NATIONAL INSTITUTE OF ALLERGY AND INFECTIOUS DISEASES

The research responsibilities of the National Institute of Allergy and Infectious Diseases include a number of respiratory disorders including allergic asthma and infectious diseases such as influenza and pneumonia. Also of concern are other bacterial, viral, and immunologic diseases that affect the lung. It was support from NIAID that led to a vaccine against pneumococcal pneumonia.

A major interest to ALA/ATS is NIAID research support directed to decreasing tuberculosis morbidity and mortality. Although the magnitude of the TB problem in the U.S. is decreasing, in part due to the introduction of chemotherapy, TB remains a serious public health problem affecting primarily minorities and the socio-economically disadvantaged.

In 1987 the Advisory Committee for the Elimination of Tuberculosis was established within the Department of HHS to provide recommendations for programs aimed at the elimination of tuberculosis. The ALA/ATS endorses the Committee's recommendations. A key component of the plan relates to research activity, such as initiatives currently underway in the Institute addressing rapid detection, improved drug therapy, and new vaccines. **An additional $16 million should be made available to the NIAID to allow for expanded research efforts on tuberculosis.**

THE NATIONAL INSTITUTE OF ENVIRONMENTAL HEALTH SCIENCES

The respiratory system is the organ system bearing the heaviest burden of environmental contamination. The National Institute of Environmental Health Sciences devotes a significant portion of its research and testing resources--approximately 20%--to the study of the lung, both as a major route of exposure and as a frequent target of damage by environmental agents.

The **Research Project Grant** provides an important mechanism of support for inhalation toxicology studies. This mechanism is crucial in order to fund additional studies regarding the pervasive and growing problems presented by urban air pollution. **An additional $5 million should be made available to fund increased numbers of grants.**

The NIEHS supports 16 **Environmental Health Science Centers**. One of the critical activities conducted in these centers is research on the health effects of air pollution and acid rain. Findings from this and other such NIEHS supported activities have provided a large share of the data used by the EPA to set health based standards under the Clean Air Act. The President's budget proposal provides no new funds for this important research mechanism. **At least $5 million in additional funds is necessary to continue activity underway as well as initiate new projects.**

The NIEHS administers the **National Toxicology Program**, established in 1978 to increase knowledge about the toxicology of chemicals including the evaluation of toxic health effects. This program is managed through the contract mechanism. The President's budget proposal provides no new funds for this area of activity. **At least $5 million in additional funds is necessary to provide for growth in this important program.**

CENTERS FOR DISEASE CONTROL

Tuberculosis is a preventable and curable disease. However, it persists as a major public problem in the U.S. and the world. Marked increases in TB in the U.S.

occur in specific populations including persons infected with HIV, minorities, the elderly and the foreign born.

In 1987 the Advisory Committee for the Elimination of Tuberculosis was established. ALA concurs with the Committee's recommendation that TB be eliminated in the U.S. by the year 2010 with a case rate of 0.1/100,000. The Project Grants program for Preventive Health Projects for Tuberculosis, administered by the CDC, is critical to most of the components of the Elimination Plan. The grant program has provided cooperative agreements for tuberculosis control activities to state and local health departments in high incidence areas. Expansion of the program is necessary to provide the additional resources to the CDC and state/local health departments for the actual elimination of TB.

The Administration has proposed in its FY 90 budget that federal funding of TB control activities be included in the Preventive Health and Health Services Block Grant rather than through the current project grant system. While the Block grant mechanism provides states with flexibility to address problems that they identify as priorities, it is a very poor mechanism for providing support for the control of an infectious disease such as TB, which is transmitted without regard for state boundaries. The Project Grant mechanism ensures that there is a coordinated interstate approach to TB control. If we are to meet the goal of elimination of TB, such coordinated effort must be maintained. **The ALA recommends rejection of the Administration's proposal, and urges the Subcommittee to appropriate the fully authorized level of $36 million of TB Project Grants.**

An expanded TB control program effort, as recommended by the Committee for the Elimination of Tuberculosis, would not only prevent the majority of TB cases in the U.S. but also save health care dollars. It is estimated that without full implementation of the Plan, elimination of TB will not be achieved until as late as 2072. More than 664,000 cases of TB will be reported in this period and of these cases, 64% would be preventable. In 1988 dollars, the prevention of more than 426,000 cases would represent a savings of approximately $6.1 billion.

The Elimination Plan, recently endorsed by Health and Human Services Secretary Sullivan, will require an all out effort that if supported by the Congress with fully authorized appropriations, can be achieved.

In conclusion, Mr. Chairman, the federal government provides a significant source of funding to a wide range of programs directly impacting the prevention and control of lung disease. The health and biomedical research programs of the federal government give strength and leadership to our entire health care system. We are now looking at opportunities in biomedical research that will lead to significant improvement in the health of the nation. Thus, now more than ever, vigorous support and adequate resources are essential.

Senator HARKIN. Thank you very much, Dr. Munzer. Did I pronounce that right? Thank you very much for your testimony.

STATEMENT OF ELLEN STRACHOTA, R.N., M.A., AMERICAN NURSES' ASSOCIATION, INC.

Senator HARKIN. Next, a long-time friend of mine, Dr. Ellen Strachota, from the American Nurses Association. She is from Des

Moines, and also serves in my Nurse's Advisory Committee. And tomorrow is National Nurse's Day.

Are you going to be celebrating?

Dr. STRACHOTA. Oh, definitely. We have to celebrate Nurse's Day.

Senator HARKIN. It is wonderful of you to be here today. I appreciate very much that you are here.

Dr. Strachota is the head of the division of nursing at Grand View College in Des Moines and very well known in her profession, not only in Iowa, but throughout the United States. So we are honored to have you here, Dr. Strachota.

Ms. STRACHOTA. Thank you very much.

Today I appear before you on behalf of the Tri-Council on Nursing, the largest national organization representing nurses in every aspect of practice.

We have submitted a detailed written statement, which I ask to have entered into the record at this time.

Senator HARKIN. Without objection.

Ms. STRACHOTA. Mr. Chairman, our Nation is in the midst of a nursing shortage so severe that it threatens to cripple our health care system. Its causes are many and complex, but the result is the same: a demand for nursing services that far outstrips the supply.

For instance, we have a growing elderly population whose health care demands require ongoing nursing care. We have an increased level of acuity in hospitalized patients. Hospitals are admitting and treating patients who are much sicker than ever before and who require intensive nursing care.

And we have special health care problems, such as AIDS and infant mortality. Ironically, the nursing shortage is occurring at a time when there are more nurses in the nursing force than ever before.

Our written statement provides you with the most recent statistics. But I would point out that in 1988, the numbers of RN's in the work force exceeded 2 million, 80 percent of whom were employed as nurses.

In an effort to address the nursing shortage, the 100th Congress reauthorized the Nursing Education Act, emphasizing several programs that will undoubtedly assist in easing that crisis.

We urgently request funding in fiscal year 1990 at the authorized level of $107.9 million for these programs.

We also recommend funding at $38.36 million for fiscal year 1990 for nursing research.

Nursing research involves the systematic study of health care problems faced by nurses every day in caring for patients.

To be succinct, nursing research allows us to find cost-effective ways to help patients get better, quicker.

One example of a project funded by the National Center for Nursing Research is in our very own State at the University of Iowa. There is a study going on the effective use of nursing interventions to promote the healing of decubitus ulcers, more commonly known as bedsores.

There are many more, but I believe you will agree with me that scientific endeavors, such as this, promise improved knowledge in the delivery of quality health care to high-risk patients.

In conclusion, Mr. Chairman, time constraints prevent me from fully defining the dimensions of the crisis our Nation is now facing and the tremendous impact it holds for nurses and all health care consumers.

Nurses are the principal care givers not only in hospitals, but also in rural areas, in nonacute settings. Our Nation needs Federal support of nursing education and nursing research more than ever before.

PREPARED STATEMENT

We appreciate this committee's past support and applaud the successes and breakthroughs made possible by your support, and urge you to fund these most vital programs at the recommended levels.

Thank you.

[The statement follows:]

STATEMENT OF ELLEN STRACHOTA

Good morning. I am Ellen Strachota, Head of the Division of Nursing at Grand View College in Des Moines, Iowa. Today, I appear before you on behalf of the Tri-Council on Nursing. The Tri-Council consists of the American Association of Colleges of Nursing; the American Nurses' Association; the National League for Nursing; and the American Organization of Nurse Executives.

The Tri-Council gratefully acknowledges this committee's past support for nursing education and nursing research. Nursing is committed to two goals. First, is improving patients' access to quality health care by ensuring that sufficient numbers of well-educated professional nurses are available to meet patients' health care needs. Secondly, we wish to improve the delivery and effectiveness of nursing care rendered to patients through the application of pertinent findings resulting from relevant nursing research. Today, we share with you our concerns and urgently request your support for continued federal funding so that these goals may be accomplished.

Mr. Chairman, I am sure you are aware of the dramatic changes that are occurring in America's health care delivery system. These changes have pervaded every facet of our society, and for nurses, hold tremendous implications because nurses are the principal health care providers for significant segments of our population, including the elderly and the disadvantaged. Nurses are the principal care givers not only in hospitals, but also in non-acute care settings such as rural and public health clinics.

Our health care system is currently facing many serious challenges. Among the greatest is meeting the health care needs of our growing elderly population. The most prevalent health care problem of the elderly is chronic illness, which, by definition, is never cured. It requires ongoing nursing care, whether in a hospital, nursing home, hospice, or the patient's own home.

Another serious challenge facing our health care system is the increasing level of acuity in hospitalized patients. Due to a variety of factors, hospitals are admitting and treating patients who are much sicker and who require more intensive nursing care. The intensity of nursing care required for these patients has increased as technologies have advanced.

Not only are we seeing more acutely ill patients in hospitals, but we are also seeing more acutely ill patients being discharged. The philosophy behind the prospective payment system to limit hospitalization and to care for patients in less costly settings has meant that many patients must be provided care in the home setting or skilled nursing facility. Their nursing care needs, however, are still great and must be fulfilled to permit maximum recovery.

A third serious challenge to our health care system is in the area of special health care problems. Two poignant examples which have had enormous impact on nursing are the AIDS epidemic and the tragedy of infant mortality. People with AIDS not only require highly skilled nursing care during episodes of hospitalization, but also need a variety of out-patient nursing services. The demand for nursing care has increased dramatically as AIDS affects a growing number of individuals. We find ourselves similarly situated with infant mortality, with America ranking the highest among eighteen industrialized nations. This high rate has underscored the need for better and more available prenatal and post-partum nursing care to reduce the number of low-birthweight babies. These, as well as other special health care problems place a particular strain on our ability to meet the health care needs of the public.

Ironically, the challenges facing our health care system come at a time when our nation is experiencing the most serious shortage of professional nurses in its history. Recent statistics reflect high RN vacancy rates in hospitals around the country. The average community hospital RN vacancy rate rose from 4.4 percent in 1983 to 11.3 percent in December of 1987. Even our military and Veterans' Administration hospitals report recruiting problems due primarily to the nursing shortage. In addition, hospitals are reporting longer time periods required to recruit RNs. The Secretary's Commission on Nursing estimates that the total number of full-time equivalent nurses needed to fill current reported budgeted vacancies in just the hospital and nursing home sectors alone is over 137,000.

Oddly enough, the nursing shortage is occurring at a time when there are more nurses in the workforce than ever before. In 1977, 70 percent of our nation's 1.4 million RNs were employed full-time in nursing. In 1988, the number of RNs in the labor force exceeded 2 million, 80 percent of whom were employed.

In spite of the increasing numbers of RNs in the workforce, the demand continues to grow, far outstripping supply. Recent data indicate a .7 percent decline in nursing school enrollments, but this leveling off is still insufficient to meet the growing demand. In view of all this, the question of whether any of us can count on a nurse being there when we, or our loved ones, need a nurse is very real. Unless we strongly and effectively support nursing education and attack the shortage head-on, we will face very serious problems in adequately meeting health care needs for many years to come.

In an effort to address the nursing shortage, the 100th Congress reauthorized the Nurse Education Act. In doing so, they included several programs which will undoubtedly help ease the nursing shortage by providing funds for basic nursing education and innovative practice models. We urgently request funding in FY 90 at the authorized level of $107.9 million for the following programs which are part of the Nurse Education Act:

First, is Undergraduate Nursing Scholarships. This is a scholarship program authorized at $30 million. Its purpose is to furnish an incentive for individuals to enter the nursing profession through the provision of increased financial support. Nurses attending school through this program must agree to work in a designated shortage area after graduation.

Secondly, is the Loan Repayment Program. This program provides loans to nursing students who agree to pay back part of the loan through service in a designated underserved area.

Third is Special Projects. This program awards grants and contracts to nursing schools and other entities for projects to combine nursing education and practice in a variety of health care settings, to improve access to nursing services in the community, and to encourage geographic and specialty distribution of nursing manpower. Special Project grants authorized include: Geriatric Training grants to provide improved education in care for the elderly; Geriatric Health Education Centers that assist schools of nursing to develop curricula relating to the treatment of health problems of the elderly; Innovative Hospital Nursing Practice Models, to demonstrate models designed to reduce nursing vacancies; Upgrading Skills, to assist licensed vocational or practical nurses and other allied nursing personnel to achieve professional nursing degrees; and Long-Term Care Nursing Practice Demonstrations, which are aimed at developing case-managed health care services in long-term care facilities.

Fourth is Professional Traineeships. These assist graduate nursing students to obtain advanced preparation to teach, serve in administrative capacities, serve as nurse practitioners, and function in other professional specialties.

Fifth is Advanced Nurse Education. This program provides institutional support to collegiate schools for the preparation of nurses at the master's or doctoral level. This includes programs to prepare nurse managers; nurse educators and clinical researchers; nurse specialists in such areas as maternal and child health and geriatrics; and nurses to provide health care in underserved rural areas.

Sixth is the Nurse Practitioner/Nurse Midwifery Training Program. Funding under this section supports programs to educate nurse practitioners and nurse-midwives.

Seventh is Nurse Anesthetist Programs. Grants provided under this program help institutions cover the costs of designing improved training for nurse anesthetists. Included are grants which provide financial support to nurse anesthetist faculty members to obtain advanced education relevant to their teaching functions.

Last, but not least, is Post Baccalaureate Faculty Fellowships. This program provides grants for nursing faculty to pursue research in areas of nursing practice which are specifically designated by law and by the Department.

We now focus on nursing research and its importance in our health care delivery system. Nursing research involves the systematic study of health care problems faced by nurses in caring for patients. A major objective is to select particular actions of nurses that are most successful in lessening the effects of illness and helping individuals and their families cope with health problems. Nursing research outcomes lead to better and more cost-effective patient care.

Nursing research projects administered through the NCNR at the National Institutes of Health address major patient care issues and have significant implications for the cost-effective delivery of quality health services. Examples of nursing research projects now funded by the NCNR include:

*At the University of Iowa, a study of effective nursing interventions to promote the healing of decubitus ulcers, more commonly known as bedsores;

*At the University of California in San Francisco, an investigation into pain management in critically ill patients;

*At the University of Kentucky, an investigation into family coping mechanisms of children receiving home intravenous therapy;

*At the University of Rochester, a study of the effectiveness of home visits by nurses to low income, "high risk" mothers. Preliminary results indicate that less child abuse, healthier babies, and better child rearing practices are evident in the homes visited by the nurses.

For the NCNR, we recommend funding at $38.36 million for fiscal year 1990. This is a significant increase over current funding but fully warranted. Clearly, scientific endeavors such as those mentioned promise improved knowledge in the delivery of quality health care to high-risk patients. At present, the NCNR is able to fund only a small percentage of approved applications. Furthermore, the NCNR currently receives less than one-half of one percent of total NIH funding.

Mr. Chairman, we are in the throes of an acute nursing shortage that poses a long-range threat to our nation's health. Curtailment of federal funding under such circumstances will not only jeopardize each of us and our loved ones, but it will prove far more costly to the nation in human and economic terms in the long run. We appreciate this committee's past support for nursing education and research, applaud the successes and breakthroughs made possible by your support, and ask for continued federal funding of these most vital programs.

Senator HARKIN. Dr. Strachota, thank you very much. As you know, the President's budget, as before, zeroed out all nurses' education. We provided $54 million last year; what is authorized next year is $107.9 million.

Dr. STRACHOTA. Correct.

Senator HARKIN. And your coalition recommends the $107.9. And I must tell you again, because of my strong feelings, as you know, personally, about the shortage of nurses that we have and how I have often said that I think nursing is our most underutilized profession in America today; that we need to put greater emphasis on nursing, nursing education, and the delivery of these services. I just mentioned one earlier, you were here when Patty Duke was here, I said about respite care for handicapped kids. It takes specialized knowledge to know how to take care of them. It is something that nursing could do, and yet nothing is being done in that area.

The elderly, as you mentioned in your testimony, which I was reading about the prospective payment system, I hear a lot from elderly people who are getting pushed out of hospitals earlier.

They may have had their acute problem taken care of, but there is a long recuperative period where they need care. That is happening now in either skilled nursing facilities or at home. And if they do not get the kind of care that a nurse can give them, they will be right back in the hospital again.

Ms. STRACHOTA. Right, so in the long run it is really cost effective to have good nursing care all the way through.

Senator HARKIN. Absolutely. Well, this is one area in which I have an intense interest, as you know, and so does Senator Inouye, and I can assure you this is one area that we will definitely pay very close attention to in making sure we get the proper funding for it.

Ms. **Strachota**. Thank you. We really appreciate that.

Senator **Harkin**. Without giving you ironclad exact dollars, that obviously has to be hammered out, but I think there is a great deal of interest here to make sure we get as much as possible.

Ms. **Strachota**. Thank you.

Senator **Harkin**. Thank you. Are you headed back to Des Moines today?

Ms. **Strachota**. Yes.

Senator **Harkin**. Say hi to all my friends out there.

STATEMENT OF DOMINICK P. PURPURA, M.D., SOCIETY FOR NEUROSCIENCE

Senator **Harkin**. Dr. Carmel is not here. Dr. Dominick Purpura, Society for Neuroscience.

Dr. **Purpura**. Thank you, Mr. Chairman.

I am Dominick Purpura. I am dean of the Albert Einstein College of Medicine and a past president of the Society for Neuroscience.

Mr. Chairman, we are human because we possess the capacity for speech, language and future planning, for self-reflective thought, and superb manual dexterity, and the capacity to walk with dignity. Stroke, head injury and brain tumors eradicate speech. Alzheimer's disease destroys memory and self-reflective thought. Parkinson's disease abolishes dexterity and multiple sclerosis, ALS and spinal cord injury immobilize.

In a word, the brain embodies the biological essence of what it is to be human and it is for this reason that disorders that impact on the brain and spinal cord have such devastating effects on the human condition.

It has been the mission of the National Institute of Neurological Disorders and Stroke since its founding to lead the Federal research effort in the basic neurosciences and the study of diseases that dehumanize our citizens, both young and old. The cost of these disorders to the nation in lost productivity and management is incalculable when factored in with the cost of human suffering.

The human brain is the most complex structure we know of on planet Earth. It is the task of neuroscience research to understand the brain and the machinery of the mind so as to provide rational guides to the cause, treatment and prevention of neurological disorders. The success of neuroscience research in the past few years is already evident in new technologies for studying memory, language, learning and thinking with brain imaging approaches and for studying basic mechanisms in epilepsy with brain slice methods.

And there is hope for replacing parts of the brain with cells capable of repairing areas of damage or destruction that occur in Parkinson's and Alzheimer's diseases.

Many of these research strategies are in the infancy of their development. They represent the synthesis of a host of different disciplines, such as neuroanatomy, neurochemistry, neuroimmunology, and molecular neurobiology—all this synthesized into a single, all-embracing concept of neuroscience as a way of thinking about brain mechanisms and brain disfunction.

This synthesis of individual disciplines in the brain sciences is, I am proud to say, a uniquely American cognitive invention. For years the United States has maintained a position of primary importance in the world in advances in brain research. But there is clear evidence today of a progressive erosion of this leadership position.

Perhaps the single most important factor in this slippage is the relative decline in the quality of research being conducted in the United States laboratories due to a continued reduction in funding for research grants and training programs. Limited appropriations reduce the number of awards that NINDS can fund at a time of unprecedented opportunity for new advances in knowledge.

Mr. Chairman, I come here as a representative of the Society for Neuroscience to support the Decade of the Brain initiative and the professional judgment budget of NINDS for fiscal year 1990 of $616 million. This increase over that of the President's budget will permit NINDS in part, among other things, to increase research project grants by 374 and training programs by 212, and to increase research centers by 19.

I recognize that this appeal would seem to be self-serving. My answer to this is, why shouldn't it be. Neuroscientists are persuaded that understanding brain as the organ of mind and the source of our humanity is the highest priority that humankind has for its own survival. Investment by the people of the United States in the brain sciences can only have one consequence—improvement in the quality of life for countless millions who suffer from neurological disorders.

PREPARED STATEMENT

I want to thank you, Mr. Chairman, for giving me the opportunity to make this statement on behalf of 14,000 members of the Society for Neuroscience.

[The statement follows:]

STATEMENT OF DR. DOMINICK P. PURPURA

Mr. Chairman, I am Dominick P. Purpura, M.D., Professor of Neuroscience and Dean of the Albert Einstein College of Medicine, Yeshiva University, New York. I come before this committee as a neuroscientist, Past-President of the Society for Neuroscience, currently President of the International Brain Research Organization which includes over 20,000 neuroscientists from 52 countries. I am a member of the National Academy of Sciences and the Institute of Medicine of the Academy. I am honored to be here representing the Society for Neuroscience and to enthusiastically endorse the professional judgment alternative budget appropriation request for the National Institute of Mental Health for $637M.

Mr. Chairman, mental illness in its various insidious forms is the single most costly disorder affecting the people of this great Nation. More than 25 million adults in the U.S. suffer from diagnosable mental disorders at any one time. Among children and adolescents 12 to 18 percent may be victims. Because mental illness is frequently shrouded in mystery and shame and stigmatizes those who suffer untold agonies, it is often hidden, ignored or trivialized than recognized and alleviated, only 20 percent of those with mental disorders receive treatment.

Reluctance to confront and conquer mental illness in our private lives has a parallel in our public policies. The mental health field has been severely underfunded relative to the national magnitude and cost of mental illness estimated at over $100 Billion. According to the Institute of Medicine, the personal and social costs of alcohol, drug and mental (ADM) disorders are comparable to those for heart disease or cancer -approximately $1000 per year for every man, woman and child in the U.S. But in FY 1988, the per capita Federal commitment to research on ADM disorders was only about $1.80. A lack of consistent, committed support for research has slowed the growth of the very knowledge and scientific manpower needed to conquer complex disorders of brain and behavior. This paucity in funding research related to mental disease has occurred at a time of unprecedented opportunities for neuroscience investigations into the basic mechanisms underlining normal and aberrant behavior.

Neuroscience research can cut the staggering costs of mental illness by moving us toward more effective and less expensive technologies. Some glimmers of decisive technology have already produced immense savings in the mental health field, thanks to an intensively developing base of scientific knowledge. The development and use of lithium as a treatment for manic-depressive illness, for example, saved the U.S. an estimated

$4 Billion during a 10-year period — $2.88 Billion in treatment costs and another $1.28 Billion in increased productivity. The discovery of carbamazepine as a therapy for lithium-resistant manic-depression is expected to save an additional $1 Billion to $4 Billion. Since people suffering from manic-depression are prone to suicide, use of lithium and carbamazepine unquestionably saves lives. An HHS-sponsored project estimated that the average life span of young adults suffering from manic-depression increases by 6 to 7 years when lithium treatment is combined with an education program. These treatments also improve the quality of life for patients and their families.

Similar advances are needed for a host of other costly, devastating, and still unconquered disorders. In the case of schizophrenia, for example, research advances that reduce by as little as 10 percent the number of episodes of illness, their duration, or their intensity would cut yearly treatment costs by $700 Million, to say nothing of the increased quality of patient's lives and productivity.

The NIMH supports and conducts a comprehensive program of basic and clinical research aimed at understanding and controlling the complex factors that underlie serious mental disorders. Recent NIMH initiatives to accelerate progress in combatting these disorders include:

° Implementing the first steps of the National Plan for Schizophrenia Research, a national research agenda issued by the National Advisory Mental Health Council in 1988;

° Capitalizing on the explosion of opportunities in neuroscience research articulated in the "Decade of the Brain" report;

° Developing a national research program to improve identification, treatment, and services for people with severe, persistent mental illness;

° Building and coordinating a coherent program of research on suicide across the life-span;

° Stimulating systematic research on AIDS, including a focus on central nervous system aspects of HIV infection and techniques of prevention.

Dramatic advances in mental health research are already evident in the following recent NIMH funded achievements:

° Identifiable and perhaps ultimately correctable genetic defects contribute to mental disorders. For example, linkages between schizophrenia and abnormalities on chromosome 5 have been disclosed in recent population genetic studies. Similarly, depressive disorders have been linked to both chromosomes 11 and the X chromosome and between Alzheimer's disease and chromosome 21. The ultimate aim of these genetic studies is to identify the gene products that are responsible for or contribute to these most debilitating disorders of the human condition. Once these products are know, safe and natural processes and therapies can be defined to diagnose, predict and prevent these disorders;

° Recent studies using magnetic resonance imaging (MRI) have disclosed distinct changes in the gross structure of the brain in schizophrenia and autism. Functional changes in the metabolic activity of the frontal lobes as compared with normals have been disclosed by other advances in imaging (SPECT);

° Pharmacological advances have permitted lithium carbonate, a drug long used in treating manic-depression illness, to be employed in diminishing - aggression and explosive behavior in children with conduct disorder;

° Discovery of a possible biological marker for Alzheimer's disease in blood platelets may greatly improve the reliability of diagnosis early in the course of this disease when pharmacological intervention may be effective;

° NIMH intramural scientists have explored the relationship between cocaine abuse and lethal convulsions and the potential therapeutic effects of the anticonvulsant drug carbamazepine in preventing the human death toll from cocaine.

To further advances in neuroscience and related research into mental disorders the Society for Neuroscience calls for selective increases in the President's proposed FY 1990 budget, which in effect represents a substantial short-term commitment and encouraging start for a number of the much needed initiatives such as the "Decade of the Brain" plan, the National Plan for Schizophrenia Research and the initiative on Mental Disorders in Children and Adolescents.

Mr. Chairman, the Society for Neuroscience requests that the President's proposed FY 1990 budget for NIMH of $487 Million be increased by $150 Million to a total of $637 Million. These additional funds will permit funding a variety of critical research and training programs such as the following:

° 450 new and competing research project grants;

° 50 research centers, 13 of which would be newly established and dedicated to such topics as suicide, child disorders, neuroscience of serious mental disorders, molecular biology, brain imaging and services financing;

° 274 research career grants, including 80 new awards;

° 2000 research trainees supported through individual and institutional awards to assure a continuing supply of superb basic and clinical investigators in the mental health field;

- 46 research and development contracts to stimulate the systematic growths of knowledge and technical expertise in key targeted areas including genetics research;
- 610 full-time equivalent staff within the NIMH Intramural Research Program to sustain its world leadership in basic and clinical mental health research.

The Society for Neuroscience champions the view that the augmented FY 1990 budget of $637 Million will facilitate the transformation of today's promises into tomorrow's realities.

- We will understand the factors that place children at risk for depression, severe anxiety disorders, antisocial behavior and substance abuse;
- We will define potential biological markers for mental disorders including Alzheimer's disease, schizophrenia and depression;
- We will provide a clearer picture of how interneuronal communication occurs under normal and abnormal conditions. This will lead to a powerful augmentation in psychotherapeutic agents;
- We will understand how the nervous system interacts with the immune system in health and disease;
- We will explore the feasibility of applying the growing array of medical and surgical techniques - including "transplants" (grafts) — to find ways to replace cortical neurotransmitter and neuromodulator chemicals in the brain;
- We will comprehend the basic mechanisms in eating disorders; the role of disturbed biological rhythms in mental illnesses and expand the opportunities for specific behavioral therapies for relapse prevention in treating addictive disorders.

In sum, the most complex behavioral process of the human brain reflect the operations of fundamental neuronal mechanisms. Neuroscience research aims to comprehend these mechanisms. It thus constitutes the driving force for a scientific approach to understanding mental illness and eventually, the treatment and prevention of aberrant human behavior, and the suffering and economic burden this entails.

Senator **HARKIN**. Let me just ask you, you asked for an increase for NIMH for how much?

Dr. **PURPURA**. NINDS, for approximately $100 million over the budget that has been proposed by the President.

Senator **HARKIN**. Thank you very much, Dr. Purpura.

STATEMENT OF DIANA J. PILLAS, EPILEPSY FOUNDATION OF AMERICA

Senator **HARKIN**. Next we will have Diana Pillas—I probably mispronounced that, too—of the Epilepsy Foundation of America.

Ms. **PILLAS**. Good morning, Mr. Chairman. That was very close.

I am Diana Pillas and I am a member of the board of directors of the Epilepsy Foundation of America, along with one of your constituents, Jim Autry, and I am also the counselor and coordinator of pediatric neurology services and the epilepsy center at Johns Hopkins University Hospital in Baltimore.

I wanted very briefly to come here in support of the NINDS' fiscal budget for 1990 but to talk to you very briefly this morning about a specific group of children at Hopkins that we are treating who have had a brain surgery called a hemispherectomy. This is in essence removal of half of a brain, one half of the hemisphere, due to intractable seizures.

When all other medical therapy has failed them, these children, who fit a very small criterion—there is a very narrow criterion for this surgery—we have done 26 of them and there are other centers around the country who have also resurrected this old, old surgery.

The spinoff of this has been calls to our center which have numbered well over 2,000, 2,000 to 3,000 in the last 2 years, most of which I have personally spoken with these families. The spinoff is that there are thousands of children out there who have intractable seizures who for even this surgery is not possible, whose only hope is that maybe someday there will be another medical therapy.

There is no respite care for these families because the families are exhausted. There is no one to care for them to even give the family a day break. Many of these children are tube-fed because they cannot even take food by mouth. And the list goes on and on and on.

Obviously these children who have had this hemispherectomy, when you remove half of the brain it creates a paralysis on the other side of the body and also makes the remaining hemisphere very vulnerable. It has attracted a great deal of media attention and that is what resulted in all of these phone calls to Hopkins. It made us realize that there are not enough people to take care of these children.

The other thing is, while we are very proud of the work we do and we are one of the centers that is very fortunate to have a very skilled and very dedicated and very caring team, and while these children are like family to us and we are proud of what we have done and the care that we give them, I think the bottom line is it is rather tragic that any child should have to give up a half a brain.

PREPARED STATEMENT

I mean, there has got to be a better way. There has just got to be a better way. And that is what I wanted to tell you this morning.

[The statement follows:]

STATEMENT OF DIANA J. PILLAS

Good morning. My name is Diana Pilllas. On behalf of EFA, its 86 affiliates throughout the nation, and the two-and-one-half million Americans with epilepsy, I am very pleased to have this opportunity to share with you our recommendations regarding next year's budget for the National Institute of Neurological Disorders and Stroke (NINDS).

I appear before you because I am a member of the Board of the Epilepsy Foundation of America. I also coordinate the provision of services and provide counseling to children with epilepsy, their parents and other family members at the Pediatric Epilepsy Center of Johns Hopkins University Hospital in Baltimore, Maryland.

I am an active volunteer with the Foundation, because as a professional working in one of the nation's few comprehensive epilepsy centers, I want to do all I can to help children of all ages - from infants and toddlers to young adults - achieve control of their seizures so they may cope with their homework, have fun with their friends and lead normal lives.

ADMINISTRATION'S REQUEST

The Epilepsy Foundation of America, as one of 38 national voluntary health agency members of the National Health Council, believes that the ongoing federal deficit crisis is delaying the applications of the research knowledge gained in recent years. This is particularly apparent in the failure to initiate so many critically important clinical trials. Federal support for neurological research, in general, and for epilepsy, in particular, is simply not keeping up with available opportunities.

The Administration's request of $480.9 million would have a deleterious effect on all neurological research including our ongoing efforts to better understand and treat epilepsy. The Epilepsy Foundation of America along with the 50 other national organisations belonging to the Consortium for Citizens with Disabilities urges you to provide an appropriation of $616.4 million for NINDS.

This amount, based on a professional judgment of research needs and opportunities, would enable the neurological research community to make a modest advance rather than a major retreat in our ongoing search for the cause and treatment of many devastating neurological disorders including epilepsy.

NEW AND COMPETING GRANTS

The President's budget request would require NINDS to reduce the number of new and competing grants by 22 percent reduction or 125 grants less than the 563 grants expected to be awarded this year. Only 30 percent of the approved grants would be awarded.

The CCD recommendation, on the other hand, would permit NINDS to support 714 new and competing grants. This number would enable NINDS to fully fund 50 percent of all approved grant applications compared to 30 percent if the President's request were enacted into law.

CLINICAL RESEARCH

EFA believes clinical research in epilepsy and many other disorders remains severely underfunded. We feel one of the most glaring deficiencies in medical research is the lack of attention to children and adults with severe epilepsy. Pharmaceutical companies have been reluctant to invest monies in this type of problem and NINDS funding for this group of patients has been extremely limited.

Clinical research in this area is admittedly difficult due to the heterogenity of the causes and seizure manifestations. However much more can be done with appropriate funding. Clinical research is more difficult to design and conduct. It is often more costly. Yet it offers the greatest hope to individuals with epilepsy and their families. It provides a mechanism where the knowledge gained through basic science is converted to improved diagnostic and treatment techniques. The President's request of $137.7 million for clinical research is wholly inadequate to meet pressing needs and existing research opportunities.

CLINICAL TRIALS

The Administration's budget also fails to provide funds for at least 13 major new clinical trials which are ready to be started during fiscal year 1990. These initiatives are in the following research areas; epilepsy; stroke; multiple sclerosis; myasthenia gravis; Guillain Barre and Parkinson's.

COMPREHENSIVE CENTERS

The contributions of multidisciplinary research centers towards advancing neurological research have been documented. EFA believes that the time is long overdue for an expansion in the budget account which funds comprehensive centers. There is a clear need for new centers, not only in epilepsy but in many other neurological disorders. In last year's Congressional testimony, Dr. Goldstein, Director of the NINDS, acknowledged that "the need for centers is great, particularly in areas of stroke, paraplegia, epilepsy and deafness."

The President's budget request of $22.5 million would maintain support for 29 centers although the amount is less than the current year's funding level. There has not been a change in the total number of centers supported by NINDS since fiscal year 1984.

The National Collaborative Perinatal Project of the National Institutes of Health, which followed the outcomes of 54,000 pregnancies, estimated that the mortality rate for neonatal seizures is approximately 35 percent. The children who survive these seizures often face many difficulties. While the NINDS has moved forward with plans to support several neonatal seizure centers, it is my understanding that funds may not be available if the President's budget submission were to be enacted.

High quality, state of the art clinical research is needed. Effective methods of technology transfer between the laboratory and the practicing physician are needed. The CCD recommendation includes $43.2 million which would permit NINDS to expand to 48 the number of centers supported during fiscal year 1990.

EPILEPSY RESEARCH TRENDS

There is no question that the epilepsy research field is ripe for further development. Recent efforts, funded primarily by NINDS, but supplemented by the research grant program of the Epilepsy Foundation of America, have built upon the advances in molecular neurobiology.

This research is providing information on how nerve cells control electrical excitability. These experiments will allow scientists to have a more specific understanding of how to develop medications that can turn off seizures or prevent the spread of seizures from one area to another in the brain. In addition, significant advances into the understanding of the genetics of epilepsy have recently occurred.

Advances in electrophysiological monitoring techniques now permit the clinician to carefully localize the seizure focus in the brain. This results in improved diagnosis and treatment of the individual with epilepsy. This, in turn, has led to the expanded use of neurosurgery to effectively treat a growing number of individuals whose seizures are resistant to drug therapy.

OVERALL NIH FUNDING

The Epilepsy Foundation of America is aware that funding decisions for individual institutes must be considered in the context of the overall level of support for the National Institutes of Health.

EFA is concerned that the President's proposed funding level of $7.529 billion (including $6.776 for non-Aids related research activities and $753 million for AIDS-related research) for NIH falls far short of the $8.093 billion needed just to maintain current services. The President's budget would permit AIDS-related research to grow by 24.6 percent while non-Aids research would be limited to an increase of only 3.5 percent - significantly less than the inflation adjustment for medical research.

The President's request would require the total number of new and competing awards to drop by 11 percent from 5,324 to 4,719 grants.

EFA, together with the other 37 national voluntary health agencies of the National Health Council and the Ad Hoc Group for Medical Research Funding, urges the Subcommittee to appropriate $8.416 billion for the National Institutes of Health. This amount reflects a consensus among voluntary health organizations, the research and academic communities and key health policy makers. It would fully support 6,420 competing research grants.

MEDICAL RESEARCH IS AN EXCELLENT INVESTMENT

Our failure to adequately fund medical research is short-sighted both in terms of human suffering and fiscal policy. One study has shown that the rate of return on every $1 invested in medical research was $13, reflecting savings accrued from reductions in absenteeism, lost productivity, and direct and indirect medical expenses. Over $10 was returned for every $1 invested in research, development and application of the measles vaccine - a yield of nearly $4.5 billion.

Yet our nation continues to spend about $2,000 per person on health care treatment, while only $25 per capita is invested in medical research. In 1987, America spent $500 billion, over 11 percent of the nation's gross national product, on treating illness, while only $14 billion, less than 1/2 percent of the GNP, was devoted to the research which ultimately could prevent these illnesses.

CONCLUSION

Epilepsy is a prime example of a medical condition in which the individual and family incur repeated direct and indirect costs. While some people with epilepsy and their families are able to shoulder this burden themselves, society absorbs much of the cost in order to sustain and support individuals who have not been able to attain economic independence due to the seriousness of their health condition or because of societal attitudes toward them.

NINDS-supported research has enabled millions of Americans with numerous neurological conditions to more lead productive, independent lives. In order to continue this progress, the appropriation for NINDS must be increased beyond the amount requested by the Administration. The Epilepsy Foundation of America, as a member of the Consortium for Citizens with Disabilities, recommends a fiscal year 1990 appropriation of at least $616.4 million for NINDS.

Thank you for this opportunity to appear before you today.

Senator **Harkin**. What kind of research are they doing to find medicine on that?

Ms. **Pillas**. The hope is that there is the continual research for new anticonvulsant therapy. These are children who have been through every single one of the medicines that are available and they are just impervious to their seizures. So this has been the only alternative.

And for the other children, because both sides of their brain have been affected, they cannot have a hemisphere removed and their seizures are intractable to all of these medications. So they just lie there and seize and hope that there will be a new medication or a new treatment soon.

Thank you, Mr. Chairman.

Senator **Harkin**. Ms. Pillas, thank you very much, and please give my regards to Jim Autry.

Ms. **Pillas**. Thank you.

STATEMENT OF J.A. PISCOPO, TREASURER, AMERICAN NARCOLEPSY ASSOCIATION, INC.

Senator **Harkin**. Mr. Piscopo, treasurer of the American Narcolepsy Association, who has testified before this committee before. It is good to see you again.

Mr. **Piscopo**. Mr. Chairman, I am the current treasurer and a director of the American Narcolepsy Association, a nonprofit organization representing approximately 4,000 persons afflicted with narcolepsy. I have narcolepsy, a sleep disorder that is characterized by inappropriate daytime sleepiness and loss of muscle control.

Narcolepsy is a lifelong illness and there is no known cure. The only available treatment today is with stimulant drugs that have many undesirable side effects. It is estimated that more than 200,000 Americans suffer from narcolepsy. For narcoleptics like me, excessive daytime sleepiness occurs every day of our lives, regardless of the amount of sleep the night before.

To illustrate the effects of narcolepsy, I was personally involved in 15 automobile accidents between the ages of 16 and 20, all of which were a result of falling asleep while driving a car. I was very lucky to survive several of them in which the cars I drove were totally destroyed.

Another example. During my 4-year college career, I slept through almost every single class I attended, even the ones I liked a lot. I was certainly lucky to graduate from college. Most people who have narcolepsy are not that lucky. It is incredible that my diagnosis of narcolepsy did not occur until I was 20 years old, after my 15 accidents and after sleeping through college.

Mr. Chairman, narcolepsy research is conducted through the National Institute of Neurological Disorders and Strokes, NINDS. In the past 3 years I have personally funded more narcolepsy research than the NINDS, nearly 2 million dollars' worth. A much higher level of funding is needed for narcolepsy research within the National Institutes of Health.

Mr. Chairman, we were very pleased with your subcommittee's response to our pleas last year. The final reports of both the Senate and the House Appropriations Committees reflected specific recommendations that greater resources be dedicated to narcolepsy research within the NINDS.

The NIH reauthorization bill passed last year also authorized a national commission on sleep disorders research. This Commission was empowered to study the state of knowledge about sleep disorders, to evaluate the existing public and private facilities and resources available for sleep disorder research, and to identify and recommend programs for improvement in the management and research into sleep disorders.

Unfortunately, Mr. Chairman, there has been no apparent increase in either the efforts or in the funding allocations for narcolepsy research by the National Institutes of Health over the last year. Furthermore, the National Commission on Sleep Disorder Research has not yet been formed, nor has any of its important work started.

We urge you to adopt even more specific and stronger language into the appropriations reports this year. The National Commission on Sleep Disorder Research must be appointed and enthusiastically supported by the NINDS.

It is now obvious that there is a need for a separate and distinct program for narcolepsy research to be established within the NINDS. Such a separate branch or program for narcolepsy should be responsible for directing and coordinating all narcolepsy and sleep-related research throughout the NIH. A specific person should be designated and given responsibility for the program that would promote greater individual accountability, public awareness and more initiative for narcolepsy research efforts.

PREPARED STATEMENT

And it would also enhance the cooperation between the NIH, the Congress and the private citizens of the United States who are concerned or afflicted with narcolepsy.

Thank you again, Mr. Chairman and the members of your subcommittee, for your continued support in our behalf for increased Federal funding for narcolepsy research.

Senator HARKIN. Mr. Piscopo, thank you very much.

How much did the NINDS fund for this last year?

Mr. PISCOPO. The numbers have not been released as of yet, but they were smaller than the year before, which was about $1.2 million.

Senator HARKIN. Thank you very much.

[The statement follows:]

STATEMENT OF J.A. PISCOPO

Mr. Chairman and members of the Subcommittee, I am pleased to appear before you today to present testimony concerning federal efforts in narcolepsy research. I am the current Treasurer and a Director of the American Narcolepsy Association, a non-profit organization representing approximately 4000 persons afflicted with narcolepsy.

I have narcolepsy, a sleep disorder that is characterized by inappropriate daytime sleepiness, disrupted night-time sleep, and loss of muscle control, or cataplexy. Narcolepsy is a life-long illness. There is no known cure. The only available treatment today is with stimulant drugs that have many undesirable side effects. It is estimated that more than 200,000 Americans suffer from narcolepsy, making it more prevalent than muscular dystrophy, hemophilia and sickle cell disease.

For narcoleptics like me, excessive day-time sleepiness occurs every day of our life, regardless of the amount of sleep the night before. To illustrate the effects of narcolepsy: I was involved in 15 automobile accidents between the ages of 16 and 20, all of which were a result of my falling asleep while driving a car! I was very lucky to survive several of them, in which the cars I drove were totally destroyed! Another example: In my entire four-year college career, I slept through almost every class I attended, even the ones I liked alot! I was certainly lucky to graduate from college. Most people who have narcolepsy aren't that lucky. It is incredible that my diagnosis of narcolepsy didn't occur until I was 20 years old, after my 15 accidents and after sleeping through college!

The social complications that accompany narcolepsy are much more than minor inconveniences or embarrassments. Sleep attacks often occur at very inappropriate times - in the classroom, at business meetings, while driving a car, during a meal, in the middle of a conversation, even during strenuous work or exercise. Learning and job performance are severely affected in children and adults, because the ability to read, study and concentrate are all impaired by narcolepsy. Parents, teachers and employers often mistake a narcoleptic's sleepiness for a lack of interest, or they mis-construe it as a sign of hostility or laziness.

Mr. Chairman, narcolepsy research is conducted through the National Institute of Neurological Disorders and Stroke (NINDS). Last year I told this Subcommittee that for the past three years I had personally funded more narcolepsy research than the NINDS, a total of nearly $2,000,000 worth! I testified that a much higher level of funding was needed for narcolepsy research within the National Institutes of Health.

Mr. Chairman, we were very pleased with your Subcommittee's response to our pleas last year. The final reports of both the House and the Senate Appropriations Committees reflected specific recommendations that greater resources be dedicated to narcolepsy research within NINDS. The NIH Reauthorization Bill passed last year also authorized a National Commission on Sleep Disorders Research. This Commission was empowered to study:

1. The present state of knowledge about sleep disorders;
2. Evaluate the existing public and private facilities and resources available for sleep disorders research, and;
3. To identify and recommend programs for improvements in the management and research into sleep disorders.

The American Narcolepsy Association and all of the narcolepsy patients in the United States were thankful for your efforts in support of narcolepsy research and the National Commission on Sleep Disorders Research. Unfortunately, Mr.

Chairman, there has been no apparent increase in either the efforts or in the funding allocations for narcolepsy research by the National Institutes of Health over the last year. Furthermore, the National Commission on Sleep Disorders Research has not been formed, nor has any of its very important work started yet!

In view of the unexplained lack of response by the National Institutes of Health and the NINDS, to the will of the Congress and the interests of narcoleptics like me, we urge you to adopt even more specific, stronger language into the appropriation's reports this year. Not only must more funds be appropriated for sleep disorders and narcolepsy research this year, but the funds must actually be spent by the National Institutes of Health! The National Commission on Sleep Disorders Research must be appointed and enthusiastically supported by the NINDS and all of NIH!

It is now obvious that there is a need for a separate and distinct program for narcolepsy research to be established within the Convulsive, Developmental, and Neuromuscular disorders program within NINDS. Such a separate branch or program for narcolepsy should be responsible for directing and coordinating all narcolepsy and sleep-related research throughout the NIH. A specific person should be designated and given responsibility for this program. This would promote greater individual accountability and public awareness, more initiative for narcolepsy research efforts, and also enhance the cooperation between the National Institutes of Health, the Congress and the private citizens in the United States who are concerned or afflicted with narcolepsy.

Thank you again, Mr. Chairman and members of this Subcommittee, for your continued support on our behalf for increased federal funding of narcolepsy research.

STATEMENT OF WILLIAM C. DEMENT, M.D., Ph.D., CHAIRMAN OF THE BOARD, ASSOCIATION OF PROFESSIONAL SLEEP SOCIETIES

Senator **Harkin**. Next is Dr. William C. Dement, chairman of the board of the Association of Professional Sleep Societies.

Dr. **Dement**. Mr. Chairman, I am very pleased to appear before you today. Dr. Purpura, who appeared just a few minutes ago, said there were 14,000 neuroscientists. There are 13,980 neuroscientists working on the waking brain and about 20 working on the sleeping brain.

I do not know quite how to say this, but sleep is sort of half of everything. You heard about epilepsy. Epilepsy is made worse by sleep. Someone testified about lung disease; that is made worse by sleep.

Some 100 million Americans have one or other of the many sleep disorders; 10 million stop breathing when they fall asleep because of sleep; 20 million have periodic leg movements that disrupt their sleep. Sudden infant death is a sleep disorder. And you just heard about narcolepsy.

The sleeping brain is more active than the waking brain and its mechanisms can fail. And that is what we have learned in the past decade. There are now over 3,000 professionals trying to treat sleep disorders throughout the United States, but today there is not one institute, one committee or even one person in the vast NIH bureaucracy who has the exclusive responsibility of fostering and advocating our understanding of the sleeping brain.

I think this has happened because of the continuing failure of the National Institutes of Health to establish a designated responsibility for reviewing and funding basic and clinical sleep research. So I support what the previous witness said and what can be done in the future.

The Congress has already taken a giant step in this direction. As the previous witness mentioned, Mr. Chairman, the Congress has established a National Commission on Sleep Disorders Research, which has the mandate to create a long-term plan for fostering basic and clinical sleep research and the applications of this research to clinical practice. We thank the Congress for establishing it.

PREPARED STATEMENT

The best and most effective thing you can do is to encourage your commission in every way. You must make sure the commission has adequate funds—I guess that would be one tire on that B-2 bomber you mentioned—to carry out its mission. You must follow its deliberations closely and you must do everything you can to implement its eventual recommendations.

Mr. Chairman, thank you for the opportunity to present the views of the Association of Professional Sleep Societies.

[The statement follows:]

STATEMENT OF DR. WILLIAM C. DEMENT

Mr. Chairman, and members of the Subcommittee, I am very pleased to appear before you today to discuss the importance of sleep disorders research, and basic research on the sleeping brain. I am a professor at Stanford University where I have studied sleep and its disorders for more than a quarter of a century. I am here today to represent the field of sleep research and sleep disorders medicine as President of the Association of Professional Sleep Societies. This national association is comprised of the Sleep Research Society, the American Sleep Disorders Association, and the Association of Polysomnographic Technologists. As of his year, we have grown to nearly 3,000 specialists around the country who are engaged in the practice of sleep disorders medicine, or who are carrying out research on sleep, fatigue related catastrophes, or clinical sleep disorders. Now more than ever, the quality of sleep and its relationship to our waking life is considered a significant factor in public health and safety.

I would like to begin this discussion by enunciating three fundamental principles which underly the true nature of sleep.

— The first principle is that sleep is an active process. When we sleep, our brains are just as active as when we are awake, and frequently very much more active. The quiescence of the body during sleep is therefore a very misleading indicator about what the brain is doing.

— The second principle is that the sleeping brain works in a way that is very different from the waking brain. One way to formulate this principle is to think of the brain as a marvelous computer with two totally different operating systems. This fundamental principle explains why it is possible to be healthy when awake and desperately ill when asleep.

— The third principle is that the activity and function the sleeping brain are purposeful and vitally necessary. We cannot live without sleep. Deprived of all sleep, organisms deteriorate and die.

I cannot over emphasize that the sleeping brain is as active as the waking brain, but works differently, and has its own unique and vital tasks to perform.

My most important message! This active, working, sleeping brain is not working properly in more than 100,000,000 Americans.

How does the sleeping brain fail? Here are some examples:

— Sleep apnea syndromes: About twenty varieties of a fundamental and deadly problem having various degrees of progressing severity afflict and sometimes kill more than twenty million Americans

— Sudden Infant Death Syndrome: More than 7000 infants yearly die suddenly, unexpectedly and tragically in their sleep because the immature sleeping brain cannot reliably maintain the life support systems.

— Narcolepsy: The sleeping brain is unable to accomplish the nightly task of restoration. As a result, more than 250,000 Americans afflicted with this illness cannot ever be fully awake.

— Insomnia: The sleep of thirty million Americans is habitually fragmented and disrupted by this sleep disorder.

— Stroke, epilepsy, and heart attacks: Something about the nature and timing of the sleep period predisposes to the occurrence of these medical catastrophes.

— The aging of sleep: The prevalences of nearly all sleep pathologies and problems increase exponentially in the elderly. What is the quality of life lived in a haze of fragmented sleep and crippling daytime drowsiness?

In addition, we poison the delicate machinery of the sleeping brain with illicit drugs and alcohol, and abuse its exquisitely timed daily rhythms with a chaotic regime of abnormal work schedules and jet travel.

Finally, at the most basic level, we simply do not allow ourselves to get enough sleep at night because the general public is unaware of the facts of promoting healthy sleep and wakefulness including the specific amount of sleep that is needed each night to be wide awake and energetic during the day.

Sleep disorders, and sleep related phenomenon are a substantial part of the total health picture. Those of us who occasionally experience sleeplessness over a period of a night or two cannot relate to the individual who experiences nightly sleep apnea episodes, causing him to wake up literally hundreds of times a night gasping for breath with accompanying cardiopulmonary distress. Or to the narcoleptic patient who even against his or her will, falls asleep while eating dinner, or talking, or driving on the freeway at 55 mph. Other sleep disorders include nocturnal myoclonus, a strangely periodic and intermittent movement of the legs that also disrupts sleep hundreds of times a night. More familiar to many are insomnia, nightmares, and night terrors. Most often individuals with chronic sleep disorders need diagnosis and treatment by specialists who are thoroughly trained in the principles and practices of sleep disorders medicine.

In the past two decades, a very small group of sleep research pioneers focused their efforts on the comprehensive nocturnal evaluation of patients. A host of illnesses were discovered that were previously unknown. The Association of Sleep Disorders Centers, an organization of facilities and specialists which provide diagnosis and treatment for patients with sleep disorders, was founded in 1975. In the absence of a specific NIH mandate and federal funds and any other outside support, a new clinical specialty, sleep disorders medicine, whose task is to diagnose serious sleep problems and provide the best available treatment, was created.

The field has been most successful in treating sleep related problems that cause excessive somnolence during the day, such as sleep apnea and narcolepsy. You probably are aware that most major cities around the U.S. have one or more accredited Sleep Disorders Centers, usually affiliated with a major medical center. We estimate that 400,000 to 500,000 Americans annually seek medical diagnosis and treatment for sleep disorders I have just mentioned. However, at the present time, it is likely that 90% or more of patients with serious sleep disorders remain undiagnosed.

The clinical practice of sleep medicine has undergone explosive growth since 1980. Yet on the other hand, research on the sleeping brain has been shriveling. Today, it is ironic that there are almost no scientists working on its basic mechanisms and functions when we can bring to bear the most advanced techniques of molecular biology, neurochemistry, neuroanatomy, and neurophysiology to some of the mysteries of sleep. On the other hand, there are more than 20,000 scientists working on the waking brain. This represents a major imbalance in the allocation of research resources, and a serious neglect of one of our most important areas of basic research. Mr. Chairman, I cannot count twenty scientists in the entire United States who are saying, "I want to devote my life to research on the mysteries of the sleeping brain." The reason is simple. Students and young investigators have not been attracted into the field because there are no clear career pathways for talented basic sleep researchers and with no place in the establishment, there are two strikes against them in the peer review system of competing for research grants.

Generally speaking, the biggest obstacle for basic and clinical sleep research has been lack of "designated responsibility" within the Department of Health and Human Services (HHS). Research in sleep disorders cuts across all medical disciplines. Yet, no established discipline or institute has been willing to take complete responsibility for the sleeping brain.

In the vast health, transportation, military, and regulatory bureaucracy of the federal government there is not one institute, one committee, or even one person charged exclusively with the task of fostering our understanding of the sleeping brain, or of promoting research on its illnesses. Sleep disorders will affect essentially every living person at one time or another, and certainly every doctor will encounter many patients with serious sleep problems.

Speaking for all sleep disorders clinicians and researchers and all our patients, I am here to say that we must have basic and clinical research on the normal and abnormal sleeping brain. We must understand its workings and its illness. With as much urgency as possible, I say that the mysteries of the sleeping brain are as worthy as the mysteries of the atom, the gene, and yes, the waking brain.

What has been accomplished with the help of the Congress?

Mr. Chairman, I am happy to note that federal and public policy makers are beginning to recognize the health and safety issues related to sleep pathology. A number of outstanding federal initiatives are taking place currently that I wish to review with you and the subcommittee, and also express our thanks to you for facilitating this activity.

The National Heart, Lung and Blood Institute (NHLBI) has initiated a program of three Special Centers of Research on Cardiopulmonary Sleep Disorders. These Centers support multidisciplinary studies that integrate basic sleep research as it relates to the regulation of the heart and lungs during sleep. The NHLBI has also begun to explore the feasibility of initiating a multicenter controlled clinical trial to determine if sleep apnea imparts significant morbidity and mortality and whether its consequences can be reversed. It is important to initiate additional funding for this program.

The National Institute on Aging (NIA) and the Office of the Medical Applications of Research (OMAR) are planning sponsor a national consensus development conference on sleep and the aging that will bring together experts from the fields of sleep research and other geriatric disciplines to discuss sleep disorders among the elderly and come to consensus on the most appropriate methods of dealing with these issues. The NIA has an excellent record in supporting meritorious geriatric sleep research.

Your Office of Technology Assessment has established a panel of distinguished experts to study biological rhythm disturbances and sleep disorders in the work place and to make recommendations. It is well known that jet lag and shift work create both a hazard and a reduction of the quality of life for millions of Americans.

The Department of Transportation has been requested by the Appropriations Committees to develop a plan for research to understand the role of sleepiness and fatigue in transportation accidents. These results will have vast applications in all work-related situations including hospitals, nuclear power plants, and the military.

The Institute of Medicine of the National Academy of Sciences has recently carried out one of its prestigious "research briefings" to examine the topic of basic sleep research. Its forthcoming report will identify outstanding research opportunities and make recommendations on how best to achieve them.

And, best of all, Mr. Chairman, the Appropriations Committees have established a National Commission on Sleep Disorders Research which has the mandate to establish a long range plan for fostering basic and clinical sleep research, the medical applications of this research, education and training, and widespread information dissemination to professionals and the general public. The commission will make recommendations for the overall administrative structure and organization for sleep disorders research through NIH and other federal agencies. We are eager to participate in the deliberations of this esteemed panel.

What can and should be done in the future?

Of the billions and billions of dollars expended for health, 99.9% go to promote the waking half of our existence. We must continue our work to elevate the sleeping brain and its many illnesses to a status more equal to the waking brain.

The second step is an appropriations mandate. There must be a clear statement that is in the best interest of the American public to carry out research on the problems of the sleeping brain including its fundamental nature.

Representing the community of sleep specialists, we would strongly recommend a specific focus for basic and clinical sleep research. Any mandate for sleep research will be fruitless, as it has been in the past, if there is not specific and very firm language requiring an integration of these efforts through the government. This process has already been initiated via your legislation creating a National Commission . This body will consist of outstanding professionals whose primary expertise is in sleep research and sleep disorders medicine, federal representatives, patients, and citizens whose clear mission is to create the national long term plan for fostering sleep disorders medicine and research on sleep and its disorders.

Meanwhile, we believe that it is essential to continue the programmatic progress that we have been making during the past several years. To facilitate this progress, a proposal has been developed which details the need, objectives, and justification for the establishment of a program of Special Centers of Research on Basic Sleep Mechanisms and Functions. Concern for the health of millions of Americans demands that we close the tremendous gaps in basic knowledge about the activity of the sleeping brain. The establishment of such a program of basic sleep research would be a crucial step in this endeavor, thereby allowing basic sleep research its essential place at the research table and assuring the preservation of our valuable research resources. Mr. Chairman, it is vital that we study the basic mechanisms of sleep and the vital functions of the sleeping brain. In this congressionally proclaimed "Decade of the Brain", it would indeed be timely to target the secrets of the sleeping brain with an integrated attack deploying the full range of new technologies and skills that are available in the many disciplines related to sleep. Mr. Chairman, in order that such an initiative be superbly planned, we ask for report language that directs your National Commission on Sleep Disorders Research to thoroughly study the proposal in concert with NIH and ADAMHA and to make recommendations to the Congress before the next budget cycle. The proposal detailing the need for Special Centers of Research on Basic Sleep Mechanisms and Functions of Sleep is enclosed for your review and consideration.

Sleep disorders medicine and study of the sleeping brain is now a fully mature discipline, and absolutely must have its independence. Independence requires a means of education and training leading to discipline identity and faculty positions, a means of support, and a special recognition of the exciting research opportunities and their enormous potential benefit to humankind. Beneath your feet, on the other side of the globe, 2 billion people are trying to sleep. Many are dying because they are sleeping. As the globe continues to turn, the billion or so now awake will also traverse the valley of the shadow of death. Healthy sleep is a blessing; pathological sleep is a curse.

Mr. Chairman, thank you for the opportunity to present the views of the Association of Professional Sleep Societies. I will be pleased to respond to questions.

Senator **Harkin**. Dr. Dement, thank you very much.

Do you have any idea how much money is being spent on research through NIH on the sleeping brain?

Dr. **Dement**. Well, it is almost less than $1 million. There is not a single grant that studies normal human sleep, for example. Basic sleep research, probably less than $4 million. In some of the peripheral clinical areas the National Heart, Lung, and Blood Institute has three scores devoted to the sleep apnea syndromes and sleep and breathing disorders.

Senator **Harkin**. In the last year or so there have been several articles about sleep and how people sleep and what happens to the brain. Maybe one of the news magazines, Time or Newsweek, had a cover story or something on it.

Dr. **Dement**. Well, there has been a tremendously exponential growth in understanding that there are sleep disorders. I think everyone assumes that when you go to sleep the brain turns off. Instead of that, it revs up and things go wrong.

It is merely that there is a tremendous gap between the amount of sleep disorders. Like say falling asleep on the highway can cost more than perhaps all of the research that is being done on basic sleep mechanism.

The Department of Transportation is now beginning to recognize the role of sleepiness in traffic accidents and hopefully will have a national educational campaign on this and make an attempt to understand it more.

Senator **Harkin**. Thank you very much.

STATEMENT OF ALVIN BLOCK, PRESIDENT, ESA, INC.

Senator **Harkin**. Next we have Alvin Block, president of ESA. Do you have a copy of any testimony, Mr. Block?

[The statement follows:]

STATEMENT OF ALVIN V. BLOCK

I am Alvin Block, President of ESA, Inc., in Bedford MA. Today, I would like to discuss the problems of our aging population, facing deteriorating health and the ever present threat of developing a debilitating disorder.

The median age in the United States is increasing each year. As we grow older we become more susceptible to the development of one of the degenerative dementias, such as Alzheimer's, Parkinson's, or Huntington's disorders. Each of these is a disease that can devastate its victim, his or her family and their entire life savings.

In any given year as many as 2-1/2 million Americans are victims of Alzheimer's disease at an estimated cost of $39 billion in health care. Huntington's and Parkinson's combined cripple some 1-1/2 million men and women at an estimated cost in excess of $2-1/2 billion.

In the behavioral area, schizophrenia affects 1-1/2 million Americans at an estimated annual cost of $30 billion. Major depression afflicts 5 million adults at a cost not easily calculated.

We are talking about many billions of dollars which represent a significant part of the total health care cost of the United States being spent each year on treating disorders without finding a cure. As the average age in America increases, these costs will continue to grow more rapidly than the increase in the Gross National Product. There is a desperate need to develop a greater understanding of these diseases and their mechanisms in order to treat them more effectively and to prevent their occurrance.

At present more units have been purchased for pharmaceutical and disorder related research in Japan than in the United States. We only recently released this instrument for sale in Europe, where the expressed interest in the instrument exceeds that in this country. I fear that the United States is going to give up its leadership in yet another field.

I would like to recommend that the United States government establish a national science policy to focus on goals and priorities in the area of health science. The US must maintain its leadership in this area. I recommend that the National Institutes of Health provide more dedicated funds for instrumentation in order to allow researchers to update their equipment on a routine basis, and to have access to the best available instrumentation in the world. It is difficult to maintain technical superiority in a field without superior instrumentation. At present, our researchers are continually falling behind our foreign counterparts. I also recommend continued support of the Small Business Innovation Research (SBIR) Program to bring together the contribution of small business to achieving government research goals. In conclusion, I would like to thank both the National Institute of Neurological Disorders and Stroke and the Division of Research Resources for their continued support. In our experience both the financial support and scientific advice of these groups have been invaluable.

ESA supports the recommendation of the ad hoc group for medical research funding of $8.4 billion for NIH for fiscal year 1990.

In the past several years, I have reported on a new technology which has been developed by ESA. We now are producing and marketing an instrument based on this technology which provides a profile of the brain's chemistry. This new instrumentation provides significant improvements in sensitivity and selectivity over any other available technique. It can measure whole neurochemical metabolic pathways, the determination of which can lead to an understanding of various disease mechanisms.

We started delivering this instrumentation to customers in early 1988. The initial experimental results from the use of these instruments are just starting to become known. In many cases our customers are reluctant to disclose their research findings until they either publish papers or achieve commercial utilization. However I can report the following applications of this instrument:

o The Massachusetts General Hospital has discovered a possible mechanism for an enzyme that controls the production of a neurotoxin. Over a period of time this neurotoxin may cause the deterioration of the brain associated with Huntington's Disease.

- Also at the Massachusetts General Hospital, research measuring patterns of neurochemicals has shown that different kinds of severe head pain, such as migraine, trigeminal neuralgia and trauma, are related to and may be caused by fundamental defects in the body's biochemistry.

- The University of California at San Diego has successfully proven genetic cell modification for the continuous generation of "L-dopa". By measuring trace levels of L-dopa, the instrument has demonstrated the potential for the use of genetically modified tissue implants in the treatment of Parkinson's disease. This would replace the concept of brain implants currently being studied for increased L-dopa production.

- In the United States, several researchers have preliminary data showing possible differences in neurotransmitter patterns between Alzheimer's disease and normals.

- In Japan, a researcher has discovered new and exciting information on the metabolic pathways associated with the use of L-dopa for the treatment of Parkinson's disease.

The technology developed by ESA has significant application in biomedical research in affective and degenerative disorders as well as in a number of other diverse areas related to improving the quality of life. For example, we recently have performed for the food industry some preliminary analyses for the quality control of natural fruit juices.

One of the primary limits to the utilization of this instrumentation in the United States is the difficulty in obtaining funding from the National Institutes of Health. Program grants generally do not provide funds for major equipment purchases. We have heard that when a research proposal contains a request for this instrument or any major instrument purchase, the grant proposal is looked upon much less favorably than if it had not included the procurement of expensive equipment. Consequently, many researchers are reluctant to risk the funding of their grant requests by asking for this instrumentation.

Senator **Harkin**. I am going to take a quick, 5-minute break. We will take 5 minutes.

[A brief recess was taken.]

Senator **Harkin**. The subcommittee will resume sitting. Mr. Block, please proceed.

Mr. **Block**. Mr. Chairman, our aging population is facing deteriorating health and as we age we become more susceptible to the development of one of the degenerative dementias, such as Alzheimer's, Parkinson's, or Huntington's.

Some 2.5 million Americans are victims each year of Alzheimer's disease, at an estimated cost of $39 billion in health care. Huntington's and Parkinson's cripple some 1.5 million men and women and cost $2.5 billion. This represents a significant part of the total health care costs spent each year on treating disorders without finding a cure.

We are now marketing an instrument which provides a profile of the brain's chemistry. This instrument measures whole neurochemical metabolic pathways which can lead to an understanding of various disease mechanisms. We started delivering this instrumentation in early 1988. Initial experimental results are just starting to become known.

In many cases, our customers are reluctant to disclose their research findings until they either publish papers or achieve commercial utilization. However, I can report the following applications of this instrument.

The Massachusetts General Hospital has discovered a possible mechanism for an enzyme that controls the production of the neurotoxin. This neurotoxin may cause the deterioration of the brain associated with Huntington's disease. The VA Medical Center at San Diego has successfully proven genetic cell modification for the continuous generation of L-dopa. By measuring trace levels of L-dopa, the instrument has demonstrated the potential for the use of genetically modified tissue implants in the treatment of Parkinson's. This would replace the concept of fetal brain implants currently being studied.

In the United States, several researchers have preliminary data showing possible differences in neurochemical patterns between Alzheimer's disease and normals, and in Japan a researcher has discovered exciting new information on the metabolic pathways associated with L-dopa for the treatment of Parkinson's disease.

One limit to the use of this instrumentation is the difficulty in obtaining funding. Program grants generally do not provide funds for major equipment purchases. We have heard that when a research proposal contains an equipment request it is looked upon much less favorably. Consequently, many researchers are reluctant to risk the loss of funding by asking for instrumentation.

At present, more units have been purchased for pharmaceutical and disorder-related research in Japan than in the United States. We only recently released this instrument for sale in Europe, where expressed interest in the instrument already exceeds that in this country.

I fear that we are going to give up our leadership again. I recommend that our Government establish a national science policy to focus on goals and priorities in the area of health science. The

United States must maintain its leadership in this area. I recommend that NIH provide more dedicated funds for instrumentation to allow researchers to have the best available instrumentation. It is difficult to maintain technical superiority in a field without superior instrumentation.

Thank you.

Senator **HARKIN**. Tell me about ESA. What is ESA?

Mr. **BLOCK**. It is a company that manufactures analytical instruments, primarily for improving health care.

Senator **HARKIN**. I am very interested in your comments on Parkinson's disease. I have a very close friend who was recently, in the last couple of years, diagnosed as having Parkinson's. I am very interested into research into that area.

Thank you very much, Mr. Block.

STATEMENT OF CHARLES M. CLARK, JR., M.D., PRESIDENT, AMERICAN DIABETES ASSOCIATION

Senator **HARKIN**. Dr. Charles Clark, president of the American Diabetes Association. Dr. Clark, please proceed.

Dr. **CLARK**. Good morning. Mr. Chairman, I am the president of the American Diabetes Association, a voluntary office. When I am not doing that I am professor of medicine at Indiana University, one of the three I-States, the one with the basketball team.

You have heard earlier today about the fact that diabetes affects 11 million people and is the leading cause of blindness. It is also a leading cause of heart disease, strokes, and the No. 1 cause of kidney failure in the United States.

These 11 million people are faced with chronic complications. We have, of course, made considerable advances in the diagnosis and treatment of the complications. When I started practice, somebody with diabetic retinopathy would inevitably go blind. Now, laser photocoagulation benefits two-thirds of the people.

When I started practice, a woman who had a pregnancy and had diabetes had one chance in five of the baby dying before birth. Now, that is less than 1 in 50. Renal disease is routinely treated with dialysis or transplantation in people with diabetes.

We have made fantastic advancements and I think that both the pain and suffering and the financial benefits of these investments in biomedical research have shown a great deal in the last decade. However, I am quite concerned with what is happening over the last particularly 4 to 5 years. As president of the ADA I have traveled over 100 days visiting all kinds of places, and for the first time, particularly among young people but also among older people, there is a sense of discouragement.

Scientists have a sense of optimism which keeps them in this. But when you have people like one of my associates, who has a grant that is better than 80 percent of all of the grants submitted to the NIH, the 18 to 20 percentile, with a letter saying you are not going to get funded this year because we do not have enough money, we are really in trouble. We are dismantling, in a quiet, subtle way, a biomedical research community which has stood us in good stead since the end of World War II.

There are certain advances now that we could make with very small investments, and I urge you to look very carefully at the coalition figures, which we support. But we have a special emphasis because we now think we can diagnose and perhaps prevent renal disease in diabetes, and we would like some special emphasis money this year, $5 million, to try to fund specific research in diabetes and renal disease.

In the last couple of years we have discovered that microalbuminurea is a sign which may suggest and diagnose renal disease 10 years or more——

Senator **Harkin**. What disease are you talking about?

Dr. **Clark**. Kidney disease in diabetes. Diabetes is the leading cause of——

Senator **Harkin**. You said renal disease?

Dr. **Clark**. Renal. Kidney, I am sorry. Renal disease or kidney disease in diabetes. Diabetes is a leading cause of kidney disease, end stage renal disease. One in two people with end stage renal disease, that will probably be the number by the end of the next decade; 1 in 3 is the number right now entering the program.

With $5 million, perhaps we can fund more than the 3 out of 65 diabetes renal disease program grants that were submitted this year. And we think that if we could prevent 10 percent of the kidney disease in diabetes we would be saving $25 million to $30 million a year with a $5 million investment.

PREPARED STATEMENT

Current cost of diabetes kidney disease, end stage renal disease, is probably right at $250 million a year, just in the treatment of that one complication. I would be happy to answer any questions you might have. We have submitted written testimony for the record.

Thank you.

[The statement follows:]

STATEMENT OF DR. CHARLES M. CLARK, JR.

Mr. Chairman and members of the Subcommittee, I am Charles M. Clark, Jr., M.D., and I serve as President of the American Diabetes Association (ADA). The Association is the nation's largest voluntary health agency serving the health care and medical research interests of over 11 million Americans with diabetes.

Diabetes is a disease in which the body does not produce or properly respond to in, a hormone needed for daily life. There are approximately one million individuals with insulin-dependent diabetes in the United States. Non-insulin-dependent diabetes represents the larger proportion of approximately 10 million individuals. In either type, serious morbidity and mortality occurs. Diabetes is among the leading underlying causes of heart disease, stroke, kidney disease and blindness. It is the number one cause of new blindness in adults aged 20 to 74. It is the number one cause of non-traumatic foot and leg amputations in the United States.

We all recognize the need for medical research, from the President to the average citizen to grade-school children. The amazing progress that we have made in curing or treating diseases that once killed or crippled millions is nothing short of miraculous. But diseases such as diabetes and scores of others help to contribute to an annual health care bill in this country of over half a trillion dollars. The cost in terms of death and human suffering are incalculable. Yet, despite all this compelling evidence, a simple fact remains: we as a society are not doing enough to combat the killers and cripplers that strike so many of our friends, relatives, and neighbors.

In 1987, the cost of diabetes to America--including direct and indirect medical expenses, lost wages, reduced productivity, and other factors--was $20.4 billion. During that same year, the amount of money NIH spent on diabetes research totaled about $234 million--or only 1 percent of this country's total health care expenditure on diabetes and its complications.

The American Diabetes Association recognizes, and is extremely grateful for, the traditional support Congress has provided for Federal medical research programs. But we must do more. The scientific challenges of tomorrow and the pressing health needs of today dictate a greater commitment from the government if we are to defeat a truly relentless enemy. During the past ten years, we have made amazing progress in the diagnosis and treatment of the complications of diabetes. Thanks to medical research early intervention in diabetic eye disease results in the saving of sight in as many as two-thirds of patients.

Other research advances and opportunities on the horizon hold similar promise for improving the health and well-being of people with diabetes. One is islet cell transplantation. Transplantation of the insulin-producing islet cells from the pancreas offers an opportunity to cure diabetes. Further research must be undertaken, however, to determine safe and effective methods to prevent rejection of transplanted cells and to ensure more efficient production of insulin from the transplanted cells.

Research on the impact of the autoimmune system on the development of diabetes appears particularly promising. Research is now underway to determine why the immune system reacts against pancreatic islet cells; clinical trials are also underway to determine the effectiveness of the use of immunosuppressive agents immediately after diagnosis to cure or delay the onset of insulin-dependent diabetes.

These and other breakthroughs, which provide a reservoir of hope for patients with diabetes, have come with comparatively modest funding. We believe that with more substantial increases in diabetes research funding, the expansion of our body of knowledge in the basic life processes related to diabetes will bring us much closer to a preventive and cure for diabetes.

AIDS is often cited as one of America's most significant public health problems. But diabetes is a growing public health problem as well. It is estimated that by 1992 the world cumulative total of deaths due to AIDS will be 250,000. That's the number of people who die from diabetes and its complications in under two years. Despite the staggering number of deaths and health costs from diabetes, however, last year the NIDDK received the fourth-lowest increase of any of NIH's institutes.

Whereas we recognize the substantial threats to our economy imposed by the Federal budget deficit, we also believe that the improvement of our Nation's health and well-being, and especially the health and well-being of 11 million Americans with diabetes, must be a top national priority.

Toward that end, we wish to offer several proposals that would ultimately maintain and bolster the vigor of our national medical research enterprise and improve the health of not only people with diabetes, but virtually all our citizens. First, the American Diabetes Association recommends a fiscal year 1990 appropriation of $8.416 billion for the National Institutes of Health. This proposal was developed by the Ad Hoc Group for Medical Research Funding, a coalition of over 150 voluntary health agencies, research institutions, and professional and academic societies.

Second, we propose an appropriation of $667 million for the research activities of the National Institute of Diabetes, Digestive, and Kidney Diseases (NIDDK). This figure would provide restoration of numbers of research project grants, full funding for diabetes research centers, and restoration of the number of research trainees that were lost due to an increase in the NRSA stipend. We very enthusiastically support a proposal, also endorsed by the Juvenile Diabetes Foundation International and the National Kidney Foundation, to provide a specific additional appropriation within the NIDDK of $5 million to provide funding for research related to end-stage renal disease caused by diabetes. Kidney failure due to diabetes is a horrendous problem. It is estimated that nearly half of all dialysis patients will have diabetes by the mid-1990s. The Kidney, Urology, and Hematology Division is currently funding only about 20 percent of the research project grants approved for funding by peer review councils; without an infusion of new funds, the Division cannot undertake any new initiatives related to diabetic kidney disease. It appears that the NIDDK will be able to support less than ten percent of the grants approved by the KUH Advisory Council Subcommittee because of the funding shortfall.

I would also like to take this opportunity to provide to the Subcommittee our recommendation for fiscal year 1990 appropriations for the Diabetes Control

Program (DCP) within the Centers for Disease Control (CDC). The DCP is an excellent example of one of the CDC's primary missions--translating the results of research to the patient care setting. The DCP has provided financial and technical support to state departments of health for establishing local advisory boards on diabetes, initiating surveillance and monitoring of the disease, and for improving patients' access to treatments that are effective in preventing the complications of diabetes. The DCP state grants program is currently funded at approximately $5 million. Direct operations for the DCP are funded at a level of $2.1 million. We recommend a six percent increase for both the state grants and direct operations accounts for FY 1990, or an appropriation of $7.5 million.

In 1987, the National Diabetes Advisory Board (NDAB) recommended that the CDC greatly expand its translation activities in order to convert state-of-the-art research findings into treatments that can help prevent the complications of diabetes. The NDAB recommended an increase of $14 million in the CDC budget for new diabetes translation activities. Congress appropriated approximately $2.4 million in both FY 1988 and FY 1989 for this account, and the President's FY 1990 includes the same amount. We request an additional appropriation of $11.6 million to bring funding for DCP translation activities up to the NDAB-recommended level of $14 million.

Mr. Chairman, we thank you and the members of this Subcommittee for the opportunity to testify on these most important medical research and health care programs. I would be happy to respond to any questions you may have.

Senator HARKIN. How many people die of diabetes a year in America?

Dr. CLARK. About 150,000 people die from diabetes directly.

Senator HARKIN. In the world or in the United States?

Dr. CLARK. In the United States. Another 150,000 people die with diabetes, complicated usually with heart disease or stroke or some other thing which is the primary cause of death, with diabetes.

Senator HARKIN. About 150,000 people die in America as a direct result of diabetes?

Dr. CLARK. Last year, that is correct.

Senator HARKIN. And how many died of AIDS?

Dr. CLARK. There are in the world, sir, according to my figures, 350,000 diagnosed cases of AIDS, in the world. In the United

States, in my understanding, there are about 75,000 diagnosed cases of AIDS.

Senator **Harkin**. That sort of puts it in perspective, does it not? Thank you very much. I appreciate your testimony.

Before you leave, how much of all this research in NIDDK goes towards diabetes research? Did you say that?

Dr. **Clark**. Our figure, as best we can estimate, is that $237 million was spent by the NIH on diabetes research last year, and in 1987, which is the latest figures we have, $24 billion was spent on the direct and indirect cost of diabetes care in the United States.

Senator **Harkin**. $237 million is last year's figure. Thank you very much.

STATEMENT OF JOHN T. FARRAR, M.D., PRESIDENT, DIGESTIVE DISEASE NATIONAL COALITION

ACCOMPANIED BY THELMA THIEL, CHAIRMAN, DIGESTIVE DISEASE NATIONAL COALITION

Senator **Harkin**. Dr. Farrar, president, and Thelma Thiel, chairman, Digestive Disease National Coalition. Did I get that right?

Dr. **Farrar**. You have got that right. The two of us will only take 3 minutes.

Senator **Harkin**. Thank you very much.

Dr. **Farrar**. Mr. Chairman, I represent both the Digestive Disease National Coalition, which is a coalition representing 22 voluntary and medical groups and 110,000 members, and the American Gastroenterological Association.

We strongly support—incidentally, my written testimony, I believe you have—we strongly support $667,479,000 for the NIDDK, and also support the $8.4 million for the NIH. The National Institute of Digestive, Diabetes and Kidney Disease—and you just heard Mr. Clark's testimony—is only in the President's budget, I guess, $577 million. We believe it should have $667 million.

PREPARED STATEMENT

Digestive disease research urgently needs support for research training, for research centers, for individual research grants, and for clinical research. The President's budget will result in fewer total research grants, as you have heard earlier from Mr. Schachman and Dr. McIntyre, and there will be a Draconian cut of 25 percent in digestive disease research centers. All of this is a substantial discouragement to young investigators on whom the future of advances in medicine depend.

I thank you very much for your past support, Mr. Chairman, and Thelma Thiel will continue.

[The statement follows:]

STATEMENT OF DR. JOHN T. FARRAR

Mr. Chairman and members of the Subcommittee, I am very pleased to appear before you today to discuss the importance of federal funding for digestive disease research through the National Institutes of Health, and specifically the National Institute on Diabetes and Digestive and Kidney Diseases.

The Digestive Disease National Coalition supports increased FY 1990 funding for basic and clinical research on digestive diseases conducted and supported by the NIDDK. Each year, over 28 million hospitalizations (that's 76,000 per day) occur resulting from digestive diseases such as inflammatory bowel disease, liver disease, and colon cancer. The medical costs alone of digestive diseases are estimated by the Digestive Diseases Advisory Board to be $17 billion per year. The total cost including lost productivity and wages approaches $50 billion per year. Mr. Chairman, disorders of the digestive system are not to be taken lightly. In terms of cost, pain and suffering, and disability, digestive diseases are among our nation's worst scourges.

The outlook for digestive disease research at the National Institute of Diabetes and Digestive and Kidney Diseases is truly alarming. Based on figures in the President's budget proposal of $577 million for FY'90, the level of funding would not even allow full funding of ongoing research project grants, which would be assessed an average 8.1% decrease. For the second straight year there would be fewer new and competing grants -- and those funded would be reduced an average of 10%. Additionally, there would be no new Centers programs and each Center would receive a negotiated reduction of a Draconian 25%. Mr. Chairman, this is not our Coalition's idea of a national commitment to biomedical research, and we believe you agree. Even in these times of fiscal constraint, we must find some way to more adequately support biomedical research. Digestive diseases are important to me and this Coalition, and that is what we will focus on today.

Budget Recommended by the Digestive Disease National Coalition

The Digestive Disease National Coalition strongly recommends an FY 1990 budget of $667,479,000 for the National Institute of Diabetes and Digestive and Kidney Diseases, exclusive of AIDS. We also support the Ad Hoc Group for medical research funding's recommendation for NIH of $8.4 billion. This funding level is essential for the Institute to sustain its record of vigorous scientific progress, and will permit:

- Full Funding of Research Project Grants -- Ongoing and newly approved research project grants would receive the award amount approved by the peer review system (as opposed to the 10% downward negotiation in the President's proposed budget);
- Higher Award Rate -- 35% of approved new and competing grant applications could be funded (as opposed to only 23% under the President's budget proposal);
- Centers -- Full funding would be provided to all existing centers, (as opposed to a 25% downward negotiation under the President's proposed budget); and the Institute could begin exploring prospects for two new Digestive Disease Centers; one in Pediatric GI, and one in Pancreatic problems.
- Training -- A total of 1009 training slots would be funded. (93 more than in 1988)
- Clinical Trials -- An increase in the contracts budget would be used to fund clinical trials currently ready to be implemented.

Mr. Chairman, the NIDDK has supported a number of successful digestive disease research projects in recent years. To support the contention that the investment in digestive disease research is sound, please allow me to recount a number of the important recent advances in digestive diseases:

- Gallstones -- Between 10 and 15 percent of adult Americans, or approximately 20 million persons in the U.S., have gallstones. Several therapeutic approaches now show promise as important alternatives to surgery, especially for selected high-risk patients. These include dissolution of gallstones through the direct infusion of a form of ether into the gall bladder or dissolution of stones by a bile acid, used alone or in combination with biliary lithotripsy therapy.

- Liver Transplantation

  - Several agents show promise in treating primary biliary cirrhosis (PBC), a progressive fatal liver disease that is the single most common indication for liver transplantation in adults. Further study of these agents may thus pave the way to reducing costly liver transplantation surgery.

  - A new chemical solution has been developed to prolong the viability of harvested organs, allow preserved grafts to survive at a higher rate, and reduce the need for costly retransplantation.

- Hepatitis -- Genetically engineered forms of interferon are promising therapy for three forms of chronic viral hepatitis.

- Inflammatory Bowel Disease -- Research into the immune system of the gut is providing new insights about the underlying mechanisms of Crohn's disease and ulcerative colitis.
- Ulcers
  - -- A bacterium has been identified as a causative agent of some peptic ulcers, and simple and reliable tests have been developed to confirm infection.
  - -- A clinical study conducted by NIDDK Intramural scientists has shown omeprazole to be a potent, long-acting inhibitor of acid production in the stomach, and thus an effective drug for ulcers. The drug demonstrates few side effects and requires only once-a-day treatment.

The Digestive Disease National Coalition's recommendation of $667 million is really the minimum level of resources that are necessary to restore funding to current and ongoing research. The level of funding would only allow partial support for several initiatives that are key to continued progress in digestive diseases. Among these initiatives are:

- further clinical study of gallstone recurrence following biliary lithotripsy therapy;
- clinical trials in the treatment of biliary liver cirrhosis;
- clinical trials in liver transplantation;
- intensified research on inflammatory bowel disease;
- Centers programs in Pediatric GI, and Pancreatic problems.

Finally, Mr. Chairman, I wish to reiterate the importance of the commitment to biomedical research within the National Institute of Diabetes and Digestive and Kidney Diseases, and all of NIH.

We urge your Subcommittee to provide $667 million for the NIDDK and $8.4 billion for the NIH for fiscal year 1990. Thank you for the opportunity to present our views.

PREPARED STATEMENT OF THELMA THIEL

Ms. THIEL. Mr. Chairman, good morning.

I encourage you to support the recommendations outlined by Dr. Farrar for the coalition. I am chairman of the National Digestive Disease Coalition and president of the American Liver Foundation.

This morning I would like to highlight a medical miracle and compare it to a national tragedy. The manmade miracle, a result of research, is the success of liver transplants. We thank you and Congress for supporting this remarkable accomplishment. Unfortunately, I lost a son 18 years ago before liver transplants were an option.

The tragedy is that no other effective treatment is available for victims of the most serious liver diseases. Liver transplants being performed at 52 institutions in this country are a treatment of last resort. Health care costs related to performing 1,682 liver transplants just last year are estimated at $306 million. Almost one-third of those patients died within the first year, a tragedy that needs to be addressed.

Federal dollars allocated to liver research at all the Institutes of Health is only about $52 million. We cannot continue to short-change liver research when we know that a larger investment in prevention and medical alternatives can cut costs dramatically.

After years of searching, a second miracle has been found. A new screening test for non-A/non-B hepatitis, now called hepatitis C, will save hundreds of lives by making the blood supply safer, preventing this disease and eliminating the need for liver transplants 15 years from now. This major research breakthrough opens the door to the development of a vaccine for hepatitis C and even an effective treatment for this devastating disease.

Promising research advances are being made in finding alternative treatments for two other liver diseases that currently are treated by liver transplantation—primary biliary cirrhosis and sclerosing colangitis.

Mysteries are being solved and lives are being saved through the efforts of highly skilled investigators. What a terrible waste of dollars and talent to cut funding for support of these unique individuals who hold the future health of our Nation in their minds. The best insurance we can buy to eliminate disease and reduce the economic burden of health care costs is stability in funding research investigators.

We must stop the attrition now to maintain the momentum. Our precious dollars need to be invested judiciously to save precious lives.

Thank you very much.

Senator HARKIN. Thank you both for your very fine and succinct testimony. We appreciate it.

STATEMENT OF CHARLES B. CARPENTER, M.D., CHAIRMAN, THE INTERSOCIETY COUNCIL FOR RESEARCH OF THE KIDNEY AND URINARY TRACT

Senator HARKIN. Next is Dr. Charles Carpenter, president of the Intersociety Council for Research of the Kidney and Urinary Tract. Dr. Carpenter, welcome. Please proceed.

Dr. **Carpenter.** Thank you, Mr. Chairman.

I am professor of medicine at Harvard and at the Brigham and Womens' Hospital and, as you said, I represent the Intersociety Council, which is representatives from all of the renal—that is the same as kidney—urology and transplantation societies and some lay groups.

We make these appearances every year to present an overview of what we think are the major issues in our field. The National Kidney and Urologic Diseases Advisory Board, which was formed by the Government a couple years ago, is getting close to its final report, and one of its findings is the magnitude of renal disease in the United States.

They have a figure now of well over 25 million American citizens who are afflicted with acute and/or chronic diseases of the urinary tract, including the kidney, and the direct health care costs are in excess of $25 billion for this. As you well know, over $3 billion of this is in direct public support of the end stage renal disease programs for dialysis and transplantation, which is a success because people do not die of renal failure any more but is still only a halfway technology because we still have incurable primary diseases.

The opportunities, we feel, have never been better, because of a lot of new basic science work that is coming on line. The problems are similar to what you have been hearing all morning, that the gradual constriction of available NIH money is producing a real crisis in our field as well. In constant dollars, the NIDDK's budget will go down $12 million to $13 million between fiscal year 1989 and fiscal year 1990, for example.

Our biggest problems this year relate to Dr. Clark's mention of the diabetes and kidney disease initiative, which the Intersociety Council has brought before Congress last year and the year before as a neglected area that requires major efforts, partly because it is the most common cause of renal failure in the country and partly because there are new basic science breakthroughs that are beginning to lead to understanding of what might be done about this disease. This is an area that is sort of on hold because of lack of specific funding.

So, among other things, we do support the proposal of the American Diabetes Association and the Juvenile Diabetes Foundation for the project that we have been promoting now for 3 years to fund $5 million for these special initiatives.

The other major concern that we have relates to the effects of other responsibilities that have been undertaken in the kidney-urology division at NIDDK to fund a large multicenter clinical trial for diet in renal disease, to fund a large data base for epidemiology of renal disease, and also to start some of these kidney and diabetes initiatives.

PREPARED STATEMENT

We find that within the NIDDK there is a 5 percent lower percentile for the RO1 scores for kidney and urology as compared to the other parts of the NIDDK, and this is producing the kinds of pressures particularly on training new investigators, about which you have heard much already today, and we are requesting that for relief that we have some restitution of funds so that we can at least have the same pay line for kidney and urology research as is available for GI and diabetes, and that is a sum of approximately $4 million.

I thank you very much for the opportunity to appear before you and present this testimony.

[The statement follows:]

STATEMENT OF DR. CHARLES B. CARPENTER

I am Charles B. Carpenter, M.D., Professor of Medicine at Harvard Medical School and the Brigham and Womens' Hospital in Boston, and Chairman of the Intersociety Council for Research of the Kidney and Urinary Tract. I am presenting this testimony on behalf of the Intersociety Council which represents the American Society of Nephrology, the American Society of Pediatric Nephrologists, the American Society of Transplant Physicians, the American Society of Transplant Surgeons, the American Urological Association, the National Kidney Foundation, the Polycystic Kidney Research Foundation, the Renal Physicians Association, and the Council on Kidney of the American Heart Association.

Mr. Chairman, the kidney and urological community is excited by recent scientific developments which have led to new NIH initiatives, some of which have been implemented and others are ready for action. These opportunities are occurring in a variety of areas, and range from application of new techniques in molecular biology to clinical evaluation of diet modification and blood pressure control to slow the progression of chronic renal disease. It is a time full of promise. I will mention some other examples to illustrate what I mean. (1) There is progress in defining the abnormal gene responsible for the development of polycystic kidney disease (PCKD). (2) For the first time there is a broad effort being mounted in understanding the cause and treatment of renal disease in diabetes, which is becoming the single most common cause of end stage renal disease (ESRD), treated with dialysis and transplantation. (3) Concerted efforts in prostatic hypertrophy and cancer are underway, aided substantially by the recently established O'Brien Kidney Centers.

As mentioned by Dr. Stuart Kleit's testimony from the National Kidney and Urologic Disease Advisory Board (NKUDAB), at least 25 million Americans are afflicted with kidney and urological diseases, and the annual direct medical costs were at least 24 billion dollars in 1985. This expense is undoubtedly higher today. We know, for example that a substantial portion of renal expenditures come directly from federal funds in support of the growing ESRD program, currently at the level of $3 Billion per year. Total NIH funding for kidney and urology research is less than 2% of the NIH budget, with approximately three quarters of it in the National Institute of Diabetes Digestive and Kidney Diseases (NIDDK). This is not a large investment in light of the costs of these diseases to society. The causes and effective treatment or prevention of the many incurable diseases of the urinary tract remain a challenge requiring sustained support of the research effort.

Each year the Intersociety Council brings before you its major concerns regarding the research needs of our field. Representatives of our societies have been presenting separate testimonies with details of specific areas of concern to our community. The National Kidney and Urologic Disease Advisory Board (NKUDAB) report on a long range national plan is being finalized, and this document will certainly contain much that we will need to discuss with you in the future. The single concern of greatest immediate import to the kidney/urology community is the subject of my testimony today, and that is the disproportionate decrease, in relation to the other branches of the NIDDK, in available research funds for kidney and urology research.

Before reviewing the particular problem facing kidney and urology research, there are two specific proposals being brought to you which I wish to mention. The first is the Center for Disease Control (CDC) proposal detailed by Dr. Darracott Vaughn, Jr., on behalf of the urology community, for funding of a new pilot initiative to study urinary incontinence. The Intersociety Council not only believes this proposal to be of high merit, but it will serve as a model for the CDC to make contributions in other areas of kidney and urological disease. The second is the proposal of the American Diabetes Association (ADA) and the Juvenile Diabetes Foundation (JDF) that $5M be provided to fund new research in diabetes and kidney disease. This is a long neglected area which has only recently, through the efforts of the renal community and the NIDDK, begun to receive the attention it deserves. Diabetes causes a unique type of kidney disease, and 30-40% of insulin-dependent diabetics now end up in renal failure and on dialysis. They account for increasing numbers of patients being transplanted. Since most of these patients do better with a transplant than on a dialysis machine, the stress on organ donor supplies and transplantation programs steadily grows. The NIDDK has made Kidney Disease and Diabetes Mellitus (KDDM) a high priority area for 3 years now, and has established support for some investigators through regular grants and the O'Brien Kidney Centers. Last year, and the year before, the Intersociety Council presented to Congress as a special priority the need to fund additional new research initiatives in kidney disease and diabetes, and we are delighted that the ADA and JDF are now joining with us in this effort. The interest and ability of the community to develop excellent proposals in this area is manifest by the numbers of applications being submitted, but the lack of additional funding has stagnated any emphasis in diabetic kidney disease. This year the Intersociety Council wishes to be on record in strong support of the request from the diabetes community for $5 Million for basic research in diabetes and the kidney.

The special problem facing the kidney and urology community this year is the sharp reduction in the funding level for regular research grants, down from the 37.5th percentile in FY88 to the 20th in FY89. The latter level compares with a 25th percentile figure for the other divisions of the NIDDK. This reduction comes as a sharp and unexpected jolt, and will impact heavily upon support of young investigators at a time when new research opportunities have never been better. We understand the general problem of restriction of research dollars as a result of Gramm-Rudman-Hollings restraints on the total budget. In addition, priorities for AIDS and Human Genome research, not set by the kidney/urology community, further place additional demands on available funds. Indeed, a steady decline in constant dollar funding of the NIDDK is apparent to us since 1987, and the 2.3% projected constant dollar reduction from FY89 to FY90 represents over $12.5M worth of research that cannot be funded. Therefore, the projected problem for FY90 will worsen in comparison to FY89. In the past 3 years or so, as the current fiscal crisis was developing, the NIDDK has made important progress in responding to major issues in renal diseases. The initiative to promote first rate research in kidney disease and diabetes, already formulated , initiated, and ready for expansion, has been mentioned already. In addition, the Modification of Diet in Renal Disease (MDRD) Study, a large multicenter clinical trial, has this year entered its third phase. This study, mandated by Congress to be conducted out of available funds, is testing the hypothesis that dietary protein restriction will greatly prolong the period before a patient approaching end stage renal disease requires initiation of dialysis treatments. Another project, which addresses important issues of concern to Congress and the scientific community, is the now established Renal Data Base, which will capture crucial epidemiological and clinical outcome data on all renal diseases found in this country. Other pressing issues have been identified, such as the high incidence of hypertension and progression to end stage renal disease in black Americans, which deserves concerted investigative efforts in the near future. What I come to tell you today is that these additional responsibilities , assumed because of their importance to Congress and the kidney/urology community, but without commensurate funding, have impacted disproportionately upon the KUH

Division of NIDDK. Attempts to buffer the shortfall from the NIDDK budget have been successful only to the point of raising the payline for regular grants in KUH to the 20th percentile. The Intersociety Council for Research of the Kidney and Urinary Tract has set this abrupt shortfall in regular research funding as our number one problem.

New investigator-initiated research applications are the life blood of any scientific field. We are particularly concerned that the impending loss of momentum in new research support will discourage bright young investigators into kidney and urology research. If they cannot be trained and subsequently supported in their laboratories, effective answers to the problems in kidney and urologic diseases will become increasingly unlikely. I am not talking about temporary delay of particular projects because of funding shortfalls. I refer to the realistic expectation that the already documented decline in applications for research training in nephrology will accelerate as it becomes known that our field is a particularly poor one in which one might receive research support. We are beginning to eat our seed corn, and do not know how long we can sustain the loss of basic research funding.

We therefore request relief from the disproportionate decline in the pay line for research grants in the KUH division of NIDDK, and request an additional $4M appropriation to NIH so that regular research initiatives in the field of kidney and urology be sustained at a level comparable to other disciplines within the NIDDK.

I appreciate this opportunity for submitting testimony, and I respectfully request that the written testimony be entered into the record of the committee.

Senator **Harkin**. You said an additional $4 million for research initiatives in the field of kidney and urology to be sustained at a level comparable to the other disciplines?

Dr. **Carpenter**. Yes; that is what it would amount to, yes.

Senator **Harkin**. I understand that. Thank you very much, Dr. Carpenter. Thank you for your patience.

STATEMENT OF SANDI BOIS, EXECUTIVE DIRECTOR, INTERSTITIAL CYSTITIS ASSOCIATION

Senator **Harkin**. Sandy Bois, with the Interstitial Cystitis Association.

Ms. **Bois**. Thank you very much, honorable chairman. Thank you for allowing the Interstitial Cystitis Association to represent our concerns to you today. Through your support over the last 3 years, we have begun to make significant strides in our goal of finding a cure for interstitial cystitis.

I am Sandi Bois. I am executive director of the Interstitial Cystitis Association in California and myself an interstitial cystitis [IC] victim. I would like to briefly share with you my story, as it is representative of so many IC patients.

At the age of 22, during my second year of law school, I first experienced the symptoms of IC. I had no idea why so suddenly I was completely debilitated by excruciating bladder pain and a constant need to urinate, up to 60 times a day. I somehow managed to graduate from law school, but I had to face the fact that my career as an attorney was over before it had begun.

Senator **Harkin**. You were here last year, were you not?

Ms. **Bois**. Our president was here, but I was here 2 years ago.

Senator **Harkin**. Two years ago?

Ms. **Bois**. Yes.

Senator **Harkin**. I remember your testimony, a couple of years ago.

Ms. **Bois**. Thank you very much.

Senator **Harkin**. I thought it was last year. I was not chairman then, but I must have been here at the time.

Ms. **Bois**. You certainly were here. I remember you very well.

I somehow did graduate from law school. Then I spent the next 4 years seeing numerous physicians to finally obtain a correct diagnosis. At first I was relieved, until I learned that IC was incurable, treatment expensive, and relief short-lived. I feel quite fortunate to be able to travel here today, due to various bladder surgeries; however, my pain is quickly returning. But today I am representing those who are too ill to leave their homes.

Interstitial cystitis is an inflammatory disease affecting the bladder wall. Valuable statistics gathered in a recent epidemiological study sponsored by The Urban Institute found that 450,000 people in the United States may suffer with interstitial cystitis. There are at least five IC patients who remain undiagnosed for every one who is, and the study calculated the economic impact of IC to be $1.7 billion.

Over the past 4 years I have spoken with literally hundreds of IC patients. These are otherwise productive citizens who have lost their careers, their marriages, their child-rearing and bearing abilities, and their ability to engage in everyday, ordinary activity. This is due to the intense, unrelenting and excruciating pain and the constant need to urinate.

I was not surprised that the epidemiological study revealed that IC patients have suicide thoughts three to four times higher than that of the general population, and a life satisfaction rating lower than that of white female kidney dialysis patients.

I am here to appeal to you today for your continued strong support for IC research. We are very grateful for the request for applications specifically on IC which was issued by the NIDDK in December 1988. The NIDDK also held a meeting in November 1988 at which the diagnostic criteria for IC research was established. Much needs to be done, and your committee's interest and support is truly appreciated by all IC patients and their families.

In your report last year you urged the NIDDK to work closely with the IC Association to establish a national registry. Sadly, this has not happened. We urge you to again support the Federal funding of a national registry for IC. This registry would allow for further analysis of the epidemiological study and for new statistics to be collected in one central location which may give us answers about IC.

PREPARED STATEMENT

To establish an IC registry we feel it is necessary for the NIDDK to hold a meeting of interested researchers, the ICA, and other directors of national registries to determine the best possible model for IC. It is imperative that IC research continue through the RFA process and we are hoping that in requesting that interstitial cystitis be included in the committee report and that at least $2 million be earmarked for interstitial cystitis funding through an RFA in 1990.

[The statement follows:]

STATEMENT OF SANDI BOI

Thank you for allowing the Interstitial Cystitis Association to represent our concerns to you today. Through your support over the last three years we have made significant strides in our goal of finding a cure for interstitial cystitis.

I am Sandi Bois. I am the Executive Director of the Interstitial Cystitis Association in California and an IC victim. Ten years ago at the age of 22 during my second year at law school I first experienced the symptoms of IC. By the time I graduated, I was so debilitated by the excruciating pain and outrageous urinary frequency (up to 50 times a day) that I had to face the fact that my career as an attorney was over before it began. I spent four years consulting physician after physician before I finally obtained the diagnosis of interstitial cystitis. At first I was relieved until I learned that this disease is an incurable one, treatment is expensive, painful and relief short-lived. Due to various bladder surgeries, I feel quite fortunate to be able to travel here today. However, my pain is quickly returning. Today, I represent those who are too ill to leave their homes.

Interstitial cystitis is an inflammatory disease affecting the bladder wall. Intense and progressive inflammation lead to deep scarring and contracture of the walls of the bladder. The result in the patient is an intense, unrelenting, excruciating pain accompanied by the constant need to urinate. The frequency of urination can be as much as 60 times a day. As a result of the pain and frequency many IC patients become totally housebound unable to work or engage in ordinary activity. This is a disease which mainly affects women -- the median age of onset being 40 years of age with 25% under the age of 30.

An Epidemiological Study sponsored by the Urban Institute found that 450,000 people in the U.S. may suffer with IC and of those patients 50% are unable to work full time compared to that of the general population. The Study calculated the economic impact of the disease to be as high as 1.7 billion dollars per annum. The Study also revealed that it took an IC patients an average of 4 1/4 years and 5 doctors to achieve a correct diagnosis of their condition. The Study found that in the U.S. there are at least 5 IC patients who remain undiagnosed for every 1 who is. This journey towards diagnosis can be frustrating and painful. Unfortunately, urologists still have difficulty recognizing this condition due largely to their early medical training and its lack of emphasis on IC.

The affect of IC on a young woman's life can be devastating. In addition to the unrelenting pain and frequent urination -- 63% of the IC patient population experience pain with intercourse -- with many being unable to have intercourse at all! This disease can cause profound damage to every aspect of an IC patient's life from one's career to one's marriage including one's childbearing and rearing ability. Suicide is a very serious problem within the IC patient population. The Study found that IC patients have suicide thoughts 3-4 times that of the general population. Their life satisfaction rating was much lower than that of the general population and was even lower than the average rating given by white female kidney dialysis patients! Many of these victims cannot even leave their homes for a short trip to the grocery store. They are trapped in a body that is torturing them day and night, with no hope of relief. There is no cure for interstitial cystitis and one quarter of IC patients receive no relief from any individual treatment.

I am here to appeal to you to continue ~~your~~ strong support for IC research. We are very grateful for the Request for Applications specifically on IC which was issued by the NIDDK in December of 1988 and for the Program Announcement which will hopefully encourage more research into the disease. The NIDDK also held a meeting in November of 1988 where a diagnostic criteria for IC was established for use in IC research. Although much more needs to be done, your committee's interest and support is truly appreciated by all IC patients, and their families.

In your Report last year you urged the NIDDK "to work closely with the IC Association to establish a national registry which would allow epidemiological data to be gathered and stored in one central location." Sadly, this has not happened. In order to find a cure for interstitial cystitis -- we need to know more about the disease and how it manifests itself over time and throughout the IC patient population. It is for this reason that we urge you to again support the federal funding of a National Registry. This Registry would allow the statistics gathered in the large scale epidemiological study to be further analyzed and updated and for new statistics to be collected in one central location. The analysis of such statistics would enable us to discover the etiology of IC and move us closer and faster towards an effective treatment and cure for IC.

We feel that in order to begin the process to establish a IC National Registry it will be necessary for the NIDDK to hold a meeting of interested researchers and the ICA to discuss the type of Registry which would be best suited for IC. There are many national registries, some of which are funded by the National Institutes of Health, which should be examined at that meeting through discussions with their current directors.

In addition to a National Registry which will help us develop a better understanding of the disease, it is imperative that IC research continue to be solicited and supported at the National Institutes of Health. To date only two IC research projects have been funded by the NIDDK. In order to be able to fund high quality proposals it is necessary to solicit them through a Request for Application process not just one year, but each year until a larger research community is established. For this reason we request that you encourage the NIDDK to issue a Request for Application again in FY 1990.

Time is running out for IC patients. Their lives depend on IC research and your support in funding them at the federal level.

We therefore REQUEST THE FOLLOWING:

1. That interstitial cystitis be included in the Senate Committee Report and that at least $2 million be earmarked specifically for the funding of IC research through an RFA and for an IC National Registry in FY 1990.

2. That a meeting be planned by the NIDDK to include the ICA, IC researchers, and directors of existing national registries to determine the best model for an IC National Registry.

3. That a Request for Proposals be issued for an IC National Registry and for IC clinical centers which would provide the Registry with standardized clinical and epidemiological data on IC patients from across the country.

Our need is great. But we are confident that with your help and with adequate funding for IC research through NIDDK, the results will be no less than miraculous. As a victim of IC, I know what it is like to endure chronic unrelenting pain. I represent those too ill to be here today. Please help us to end our suffering. Help us find a cure for interstitial cystitis. Thank you.

Senator HARKIN. In our report last year we urged NIDDK, as you said, to work closely to establish a national registry. You said sadly this has not happened. Do you know why it did not happen, or it just did not happen? I will ask them why. I just wondered if you might know.

Ms. BOIS. Thank you very much. We would like to understand why. My understanding is that they are now proposing a plan for an IC data base, which is extremely limited and will not give us the type of information that we need. It will not include the valuable epidemiological study information that we have. And it would be a very, very narrow pool of names, and that is what they are proposing.

Senator HARKIN. Do you know how much money is spent totally on IC research now?

Ms. BOIS. At this point, $1.1 million has been spent in fiscal year 1987 and again in fiscal year 1988.

Senator HARKIN. And you are asking for $4 million?

Ms. BOIS. $2 million.

Senator HARKIN. Sounds reasonable to me.

Ms. BOIS. Thank you very much.

Senator HARKIN. Thank you very much, Ms. Bois.

STATEMENT OF JUDITH COCHRAN, JUVENILE DIABETES FOUNDATION

Senator HARKIN. Last, Ms. Judith Cochran, Juvenile Diabetes Foundation.

Ms. COCHRAN. Mr. Chairman, my name is Judy Cochran, and it is a privilege to appear before you to discuss fiscal year 1990 funding for the National Institutes of Health. I appear before you today as a member of the International Board of the Juvenile Diabetes Foundation [JDF], a voluntary health organization which has raised over $58 million for diabetes research since 1971.

I choose to work as a volunteer for this organization because of JDF's unwavering commitment to the proposition that through research we can cure diabetes and improve the quality of life of the diabetic.

I appear before you as a parent of a diabetic daughter, Adena, who has had type 1 diabetes for 12 of her 18 years. I also appear before you as a taxpayer concerned with the economic drain of diabetes on our economy, estimated to be approximately $20 billion per year.

When JDF was founded 19 years ago, there was no Federal diabetes research program to speak of: 14 years ago this committee had the courage and the foresight to direct NIH to implement the recommendations of the National Commission on Diabetes' long-range plan to combat diabetes. Thanks to your wisdom and foresight, we have a comprehensive and multifaceted research, prevention, education and control program that has come into its own, a model for biomedical research and many times emulated to attack other major health problems.

Two years ago, the National Diabetes Advisory Board had recently issued its revised long-range plan. We now have a blueprint for a cure. JDF believes that funding at our recommended levels, the 18-percent increase in NIH funding that is supported by over 100 health organizations, would provide the impetus for commencing implementation of a number of the significant elements of this plan.

In addition to our recommendations for overall NIH funding, I am here to ask for your special attention to an extraordinary problem. JDF, in concert with the American Diabetes Association and the National Kidney Foundation, is seeking this subcommittee's support for a special appropriation of an additional $5 million to be targeted for basic research into diabetic kidney disease.

Consider the following. Death from kidney disease is 500 times more common among young adults with insulin-dependent diabetes than in the general population. Diabetics comprise approximately 30 percent of patients in the end stage renal disease program. We are spending roughly four times as much dialyzing diabetics than on research to cure diabetes.

By the mid-1990's, diabetics will account for one-half of all dialysis patients. This is a tragedy of staggering dimensions. As the parent of a diabetic, I am truly terrified. As a taxpayer, I can only conclude that we must address the monumental problem of diabetic kidney disease now with a modest investment of $5 million. It makes good health policy sense. It makes good economic sense.

Over the past 15 years you have heeded our call and provided funds for diabetes research. Your investment has paid off with enormous dividends. We can point to major success in the treatment of this Nation's diabetics. And, unlike a decade ago, we now have a reasonable basis for being optimistic about a cure and prevention of this insidious disorder.

With Federal research dollars scientists have isolated a virus that triggers diabetes, leaving the possibility of a preventive vaccine. With Federal research dollars scientists have made it possible for the majority of diabetic women to have normal pregnancies for the first time. With Federal research dollars millions of diabetics are benefiting from new drugs and new ways of taking insulin.

Because of Federal research dollars, diabetics can now avail themselves of laser coagulation therapy to great diabetic retinopathy and significantly reduce the risk of blindness. With Federal research dollars, scientists have initiated clinical trials in which humans are undergoing pancreatic islet cell transplantation. Utilizing the same technology, investigators have actually cured diabetes in laboratory animals.

Mr. Chairman, this is why we are here, to achieve the promise of a cure, to eradicate a disease which is a leading cause of death, blindness, heart disease, kidney failure, and neurological disorders, to continue to provide hope for this country's 12 million diabetics and their families.

Ten years from now, will we feel a great sense of reward because the research advances funded today have yielded a cure for diabetes? Or will we look back over a long line of opportunities foregone in a diabetes program which failed to attain its mission for want of adequate Federal support? Will we need another long-range plan to combat diabetes?

PREPARED STATEMENT

We hope that once again this committee will ignore the expedient and do what you know in your hearts is right by providing an 18-percent increase in funding for the National Institutes of Health for diabetes research and earmarking $5 million for basic research in diabetic kidney disease. There is a cure, and together we will find it.

Thank you.

[The statement follows:]

STATEMENT OF JUDITH COCHRAN

The Juvenile Diabetes Foundation International (JDF) appreciates this opportunity to present its views regarding FY 1990 appropriations for the National Institutes of Health and other federal diabetes programs. JDF is an international voluntary health organization of over 160 chapters and affiliates throughout the U.S. and the world dedicated to furthering research in diabetes and improving the quality of life of the diabetic.

A DECADE OF REMARKABLE PROGRESS.

Fourteen years ago, the federal government embarked upon its efforts to implement the National Diabetes Advisory Board's (NDAB) initial Long Range Plan to Combat Diabetes. At that time, there was no federal diabetes initiative to speak of -- little funding and no infrastructure. The biomedical research community's commitment to diabetes research could be characterized as benign neglect of a disease which wreaked havoc upon virtually every body system -- the eyes, the heart, the kidney, the nervous system -- draining the spirit and resources of young families facing life with a child with an incurable chronic disease and sapping the economy of billions of dollars in health care and lost productivity.

The Federal Diabetes Program.

Several of you who served on the Appropriations Committee at that time heard our message. This Committee and the Congress created the National Commission on Diabetes, which, in 1975, issued the first Long Range Plan to Combat Diabetes. This Plan provided the blueprint for a major research onslaught on diabetes. The Congress directed NIH to create a multi-faceted research, prevention, education, and control program that, since that time, has come into its own and is now a model for the entire biomedical research community.

AT THE CROSSROADS: A CRISIS YET UNRESOLVED.

Congress' willingness to invest in the Long Range Plan has yielded remarkable dividends in terms of ameliorating the human suffering which accompanies the scourge of diabetes and providing the potential for a cure. Despite the cause for optimism in diabetes research, diabetes continues to exact enormous human and economic costs. In the United States:

*Diabetes is the third leading cause of death by disease.

*Diabetes is the leading cause of new cases of adult blindness.

*Diabetes accounts for 30 percent of new cases of end stage renal disease (ESRD), and is projected to account for 50 percent of these cases by the year 2000. It is for this reason that JDF, in conjunction with the American Diabetes Association and the National Kidney Foundation, is seeking a special appropriation of an additional $5 million for research in diabetic kidney disease.

*Diabetes is the cause of over 40,000 amputations costing an estimated $302 million each year, excluding rehabilitation or disability costs.

*Heart disease is twice as common and more often fatal in diabetics than in the general population.

*Diabetic women's babies have a three-fold increase in frequency of birth defects, a five-fold increase in other complications that require early intensive medical care, and a higher mortality rate than babies born to non-diabetic women.

The revised Long Range Plan also expounds a tale of a disease with staggering economic dimensions. According to a recent study by the Center for Economic Studies in Medicine, the total annual direct cost attributable to diabetes is $20 billion. Annual savings of $454 million in the national cost of care for the blind can be realized through the use of laser therapy in advanced cases of diabetic retinopathy. To illustrate the necessity of investing in the search for a cure, we need to realize that the federal government currently spends twice as much to dialyze diabetics as it does to cure the underlying cause of end stage renal disease -- diabetes; in no other area is it more essential that we harness enhanced research support. Moreover, the potential savings involved in translating research advances "from bench to bedside" are even more phenomenal when one considers that diabetics now account for about 30 million hospital days per year.

A TIME FOR RECOMMITMENT: JDF's FY 1990 APPROPRIATIONS RECOMMENDATIONS.

Administration Budget.

While the Administration has in fact proposed an increase of 3.6 percent for the overall NIH budget - exclusive of AIDS-related support - for FY 1990, the Department of 'ealth and Human Services estimates that, for the second consecutive year, significantly fewer new and competing research grants would be funded in FY 1990. Specifically, it is estimated the number of new and competing grants would fall by 572, or 11.2 percent, under the Administration's budget request. In FY 1989, the number of approved grants dropped by 14.8 percent, from 6,018 in FY 1988 to 5,128. To make matters even worse, NIH was forced to reduce the dollar amount of grant awards by an average of 10 percent. In 1990, it is projected that there will be an additional 9 percent cut in competing grant awards and a 10 percent cut in noncompeting awards. Moreover, only three out of ten approved research grant applications at NIH will be funded in FY 1989. Thus, the Administration proposal falls well short of what is needed to maintain current research momentum at NIH.

In recent years, our national commitment to medical research has not kept pace with research and development budgets across the government. According to the National Science Foundation, federal funding for research and development at the Department of Defense, measured in 1978 constant dollars, has increased 98 percent over the past 10 years, while spending for health research at NIH and ADAMHA has increased only 17 percent during the same period.

The Ad Hoc Coalition's for Medical Research Recommendations.

The dividends from the federal investment in biomedical research -- a healthier America -- warrant an NIH investment comparable to government- wide funding increases for research and development. As we approach a major turning point in biomedical research in general, and diabetes research in particular, we must make a determination as to whether we follow the path of retrenchment or the path towards capitalizing on scientific opportunity.

For us, the choice is clear. JDF recommends that Congress appropriate $8.4 billion for NIH in FY 1990, as allocated on the table of recommendations appended to this testimony. Along with over 100 scientific and voluntary health organizations, we recommend that the National Institutes of Health be funded at the levels adopted by the Ad Hoc Group for Medical Research Funding. This request represents an 18 percent increase in the NIH budget for FY 1990.

Under this proposed budget, NIH would fund about 6,420 competing research grants. The proposal would also facilitate the funding of 33 percent of approved research grant applications. In addition, all grants should be awarded at study section-recommended levels and not be subject to downward "negotiation" which embodies the potential to compromise the quality and integrity of NIH-supported research. In order to ensure program balance, all mechanisms, including training, centers, cooperative clinical research, and intramural research, should be increased by the same percentage as research project grants.

Diabetes-Specific Initiatives.

Funding for the National Institutes of Health at the levels recommended by the Ad Hoc Group for Medical Research Funding, including our recommendation of $667 million for the National Institute of Diabetes and Digestive and Kidney Diseases, would enable NIH to commence implementation of the more significant recommendations of the National Diabetes Advisory Board's Long Range Plan:

Diabetic Kidney Disease.

Diabetic kidney disease is an area of enormous and growing concern within JDF and the entire diabetic community. According to NDAB statistics, nearly one-third of new cases of ESRD in this country are directly attributable to diabetes. In addition, approximately one-third of people with insulin- dependent diabetes have diabetic nephropathy, and death from kidney disease is 500 times more common among young adults with insulin dependent diabetes than in the general population. The Federal ESRD program provides care for approximately 130,000 patients at a cost of $3 billion - diabetics comprise approximately 30 percent of the patients in the program. Moreover, the total number of diabetic patients in the ESRD program has been increasing 10 percent annually, and within the next few years the number of diabetics is expected to reach 50 percent.

While the outlook for patients with diabetic kidney disease is not as bad as it once was, early diagnosis and prevention are still elusive. Additional basic information is needed regarding the exact causes of diabetic kidney disease.

Both the NDAB and the National Kidney and Urologic Diseases Advisory Board have identified a number of "future directions" for kidney-related diabetes research. Because of the devastating complications of diabetic kidney disease and the resulting human and economic costs, JDF, in concert with the American Diabetes Association and the National Kidney Foundation, seeks this Committee's support for a special appropriation of an additional $5 million targeted for basic research into the cause, diagnosis, prevention and cure of diabetic kidney disease. There is an acute need for basic research into this complication since there is still much we do not fully understand. We strongly believe that a modest investment in this area could reap huge benefits, both in terms of alleviation of human suffering and cost savings for the federal government.

Diabetes Interdisciplinary Research Programs.

JDF supports the recommendation of the NDAB that NIDDK establish several Diabetes Interdisciplinary Research Programs. The new programs would be designed to integrate diabetes-related research and diabetes-oriented scientists, both young and established, into existing basic science laboratories to capitalize on exciting new basic science methodologies for the benefit of diabetes research. Experts in diabetes now recognize the benefits that basic science disciplines - such as genetics, molecular biology, virology, protein chemistry, receptor signalling, and immunology - could contribute to the accumulation of vital knowledge about diabetes.

RESEARCH MANPOWER TRAINING.

According to recent reports of the National Academy of Sciences (NAS) and the National Science Foundation (NSF), there is a critical shortage of biomedical scientists and a likelihood of far greater shortages in the future. The current national research manpower problem can be gauged by examining the field of diabetes. From FY 1980 to FY 1988, expenditures for diabetes-related manpower programs supported by the NIDDK have decreased from $7.4 million to $5.0 million, while the total number of individuals receiving support has declined from 312 to 172.

In FY 1989, these training programs incurred an additional setback that will result in further reductions in the number of research trainees. Trainee stipends were increased in FY 1989 to keep the training program competitive with other career opportunities for young physicians and scientists. However, additional funds were not provided for this added expense, thus requiring NIDDK to further reduce the number of trainees that could be supported in FY 1989 and in future years.

Funding at our recommended levels would allow an increase in the number of trainees to the level recommended for NIH by the NAS and allow implementation of the research manpower training recommendations contained in the 1987 NDAB Long Range Plan.

CENTERS FOR DISEASE CONTROL (CDC).

The cost-effective application of current diabetes treatment information is being demonstrated through diabetes control programs in 20 states, but this program has been severely hampered since its inception because of inadequate funds to fully support various intervention projects.

JDF believes that these state diabetes control programs should be adequately funded and that Congress should provide $5 million to support continued development of the Diabetes Translation Center at CDC.

CONCLUSION.

Several of the members of this Committee have made history. You helped create the National Commission on Diabetes, whose Long Range Plan became the foundation for the federal diabetes effort. The research which you have funded over the past fourteen years has yielded huge dividends in terms of reduced diabetic mortality and morbidity and reduced health care expenditures. The NDAB continued its work and has provided the Congress and the diabetes community with a revised blueprint for research, training, education and control. The task at hand is to seize the initiative and fully implement these important recommendations.

Ten years from now, will we feel a great sense of reward, because the research advances funded by Congress today have yielded a cure for diabetes? Or will we look back over a long line of opportunities foregone, and a diabetes program atrophying for want of federal support? There is a cure and together, we will find it.

JUVENILE DIABETES FOUNDATION INTERNATIONAL: FY 1990 APPROPRIATIONS RECOMMENDATIONS

(in millions of dollars)

National Institutes of Health	FY 1989 Appropriations	Diabetes Dollars in FY 1989	Admin. Est. FY 1990	JDF Recommendation
NCI	1,571.5	.90	1,646	1,854.4
NHLBI	1,045.9	16.4	1,082.5	1,234.2
NIDR	130.8	3.1	135.8	154.3
*NIDDK	559.7	154.3	582	672
NINDS	480.2		502	566.6
NIAID	743.6	6.7	842.7	877.4
NIGMS	682.3	2.6	781.3	805.1
NICHD	425.6	13	444.2	502.2
NEI	231.3	21.7	239.5	272.9
NIEHS	223.7	.2	230.8	264
NIA	222.8	5.5	230.5	262.9
NIAMS	160		168.6	188.8
NIDCD	87		91.4	102.6
DRR	358.5	17.5	308	423
NCNR	29.1		31	34.3
FIC	14		15.5	16.5
NLM	74.4		78.7	87.8
OD	68.2	.5	96.6	80.5
B&F	38.5		21.6	45.4
TOTAL NIH	7,147.2	252.7	7,528.7	8,400

* JDF, in concert with the American Diabetes Association and the National Kidney Foundation, is seeking a special appropriation of $5 million for basic research into diabetic kidney disease.

Senator **Harkin**. Thank you very much, Ms. Cochran, for your patience in being here and for your fine testimony. Certainly this is an area of great concern to us and we will see what we can do. Thank you.

SUBCOMMITTEE RECESS

The subcommittee will stand in recess until 9:30 a.m., Monday, May 8, when we will meet in SD–192 to continue our public witness hearings on the administration's fiscal year 1990 budget request.

[Whereupon, at 12:12 p.m., Friday, May 5, the subcommittee was recessed, to reconvene at 9:30 a.m., Monday, May 8.]

DEPARTMENTS OF LABOR, HEALTH AND HUMAN SERVICES, AND EDUCATION AND RELATED AGENCIES APPROPRIATIONS FOR FISCAL YEAR 1990

MONDAY, MAY 8, 1989

U.S. SENATE,
SUBCOMMITTEE OF THE COMMITTEE ON APPROPRIATIONS,
Washington, DC.

The subcommittee met at 9:36 a.m., in room SD-192, Dirksen Senate Office Building, Hon. Tom Harkin (chairman) presiding.

Present: Senators Harkin, Specter, and Hatfield.

NONDEPARTMENTAL WITNESSES

Senator HARKIN. The Subcommittee on Labor, Health and Human Services, Education and the 17 related agencies will come to order.

Today we will continue our public witness hearings. We will hear testimony from approximately 150 witnesses. I want everyone to know that anybody who submits testimony, prior to May 15, will have their testimony put in the hearing record.

Because of the necessity to move this along, we have a red light/green light system. You will be given 3 minutes, the green light will go on, then the yellow light warning and when the red light comes on, we would like you to finish up. This is so that everyone gets a fair and equal opportunity to be heard.

Moving right along, our first several witnesses are representing special children's issues. We will then continue with NIH topics.

STATEMENT OF MARY BOURDETTE, CHILDREN'S DEFENSE FUND

Senator HARKIN. First this morning is Ms. Mary Bourdette of the Children's Defense Fund [CDF]. Ms. Bourdette, welcome to the committee.

I will say this once. All of your testimony will be made a part of the record in its entirety. Again, we welcome you, and if you would please summarize, I would appreciate it.

Ms. BOURDETTE. Thank you, Mr. Chairman. Mary Nettleman and all of us at the Children's Defense Fund very much appreciate the opportunity to appear before you today and want to thank you for the long tradition of this subcommittee in your persistent leadership on behalf of programs for children.

Your persistence has certainly not been in vain. The American public finally recognizes that our children have been neglected, and, as recent polls confirm strongly now supports additional investments in children and families. As you know, leaders in the business and academic and political communities have also now united strongly in support of additional national investments in children.

Specifically, programs for young children, child care and early childhood development in Head Start, in chapter 1, in childhood immunizations, and other successful cost-effective preventive programs for young children.

The strong bipartisan support for these additional investments in children, and the fact that with very scarce resources, as you know, the Senate budget resolution and the House budget resolution as well, target significant additional new funds for these very efforts for child care and Head Start and child health programs. We know this provides an opportunity, we hope, for this committee to move forward on them.

CDF strongly supports these priorities and particularly urges your investment this year in three essential efforts—child care, Head Start, and childhood immunizations. You know these programs are needed, you know funds for them are needed. All of them have strong and bipartisan support, and all of them are supported by the budget resolution in both the House and the Senate.

First and foremost, we recommend that this subcommittee appropriate at least $1.8 billion in new funds for the Act for Better Child Care, S. 5, this year. We recognize that ABC is a new initiative and that its legislative progress may not be in full sync with your own. But it has overwhelming support. The Senate budget resolution, as well as the House, specifically targets additional funds in function 500 for this effort. As you may know, the full Senate is expected to take up ABC in the next few weeks and we expect favorable action on child care this year.

You know, more than others, that we face a serious child care crisis in this country and that the lack of safe and affordable child care is jeopardizing the health and safety and early development of millions of children. Again, this is a difficult new initiative, but we hope you will reserve at least $1.8 billion in new funds for this year.

Second, we urge you to appropriate $317 million in additional funds for Head Start this year, bringing the program's funding level to $1.552 billion. Again, this is the funding level recommended in authorizing legislation by the Senate Labor Committee, it is specifically endorsed and supported by the Budget Committee, and it is the appropriation level that would be required to fund the 95,000 additional children recommended by President Bush.

Third, we would hope you would appropriate $35 million in additional funds for childhood immunization, for special outreach efforts, for low-income infants and toddlers in high-risk areas.

PREPARED STATEMENT

There are many, many other programs for children and families that we hope you will recognize this year in your fundings efforts and that are outlined in our written testimony. We hope to work with you in the months ahead to pass a Senate Labor-HHS bill that places priority in these very important efforts, child care, Head Start, immunization, as well as many others.

Thank you, Mr. Chairman.

[The statement follows:]

STATEMENT OF MARY BOURDETTE

The Children's Defense Fund appreciates the opportunity to appear before you today. This Subcommittee has long recognized that the real strength, security and economic vitality of our nation depends ultimately upon the full and healthy development of America's children. Tragically aware that the status of our children has been steadily deteriorating with potentially devastating consequences for us all, the members of this Subcommittee have persistently lead efforts to invest in children's health, early development, education and training.

Your persistence has not been in vain. In overwhelming numbers, the American public also now recognizes that our children have been neglected (see April, 1989 Louis Harris/ Phillip Morris Company poll) and strongly supports national action on their behalf. Leaders in the business, academic and political communities have united in support of urgent national investments in children. Broad bipartisan consensus has been reached that such investments must start with our youngest and most disadvantaged children, and priority must be given to investments in preventive programs of proven success and cost-effectiveness -- in quality child care and early childhood development, Head Start, Chapter 1, and childhood immunizations. Reflecting this consensus, the Senate Budget Resolution for FY 1990 targets scarce additional federal funds to these very priority programs as does the President's Budget request.

The Children's Defense Fund supports these priorities and urges the Subcommittee to invest additional new funds in them this year so that more of our youngest children may grow up to be healthy, educated and productive adults.

Quality Child Care: CDF recommends that this Subcommittee appropriate $2.5 billion in new funds for the Act for Better Child Care (S. 5). We recognize that ABC is a new initiative, but it is a critical initiative urgently needed by America's children, families and employers. Recognizing the overwhelming support for ABC, the Senate Budget Resolution specifically increased discretionary funding in budget function 500 for it, and the full Senate is expected to take favorable action on ABC this month.

Our nation faces a child care crisis of growing proportions as millions of families cannot find or afford decent care for their children while they are at work. As a result, far too many children, especially low income and disadvantaged children, are left alone or in unsafe, inadequate care, jeopardizing their early development, and in some cases, their very survival. We urge this Subcommittee to ensure quality care for America's young children by including $2.5 billion for ABC in the FY 1990 Labor, Health and Human Services appropriation bill.

Head Start: CDF also recommends that you appropriate $1.552 billion for Head Start for the 1990 fiscal year, or $317 million over FY 1989 levels. This funding level is supported by the Senate Labor and Human Resources Committee, the Senate Budget Committee, and it is the amount necessary to add 95,000 disadvantaged preschoolers to the the program as recommended by President Bush.

It is well recognized that Head Start provides invaluable early childhood development services for poor and disadvantaged three- and four-year-olds, yet less than 20 percent of those eligible have services available to them. We urge this Subcommittee to embark on a plan to provide Head Start to all those eligible for and in need of its services over the next five years. We hope you will take the first step in FY 1990 by adding $317 million to this critical program.

Chapter 1: We recommend an appropriation of $5.070 billion for the Chapter 1 Compensatory Education Program in FY 1990, an increase of $500 million over its FY 1989 level. Again, the Senate Budget Resolution included Chapter 1 among its priorities for increased domestic funding this year, and you have heard from many other witnesses about the importance of this program for the education of low income and disadvantaged students. We hope that you will also place priority on Chapter 1 and increase its funding by $500 million in FY 1990.

Childhood Immunizations: We recommend an appropriation of $177 million for the Immunization program in FY 1990, an increase of $35 million over current spending. Supported by the program's authorization and the Budget Resolution, these additional funds are critically needed to protect very young children from preventable diseases. It is especially important that funding be provided to protect infants from Hepatitis B and from meningitis with the newly refined HIB vaccine, and to undertake outreach efforts directed toward immunizing infants and toddlers in high risk areas.

Childhood immunizations are one of the most cost effective investments possible. Each $1 spent to immunize a child can save more than $10 by reducing childhood death from illness. We urge you to invest an additional $35 million in Immunizations in the 1990 fiscal year.

Children, of course, have many and varied needs, and we hope you will support additional funds for other programs vital to ensure the health of children, protect them from abuse and neglect, and prepare them for a productive future. The Children's Defense Fund also recommends funding increases for the following children's services in FY 1990:

- **Child Welfare Services:** We recommend an appropriation of $266 million in FY 1990 (an increase of $19.3 million). The numbers of abused or neglected children have increased over 90 percent since 1981. We must reach more children and families and better support overwhelmed and overworked child welfare agency workers.
- **Child Adolescent Service System Program (CASSP):** We recommend a FY 1990 appropriation of $10 million (an increase of $1.9 million). Forty states effectively use CASSP funds to coordinate services and resources to help children with serious emotional problems.
- **Transitional Living Block Grant Program:** CDF recommends a FY 1990 appropriation of $10 million for this program authorized by last year's Runaway and Homeless Act. This program is critical to help the ever increasing numbers of homeless young people who do not have families to return home to.
- **Lead Poisoning Prevention Program:** CDF recommends an appropriation of $22 million for this program in FY 1990 so that states and communities can find and screen at-risk infants and children for excessive and potentially harmful lead blood levels.
- **Maternal and Child Health Block Grant Program (MCH):** CDF

recommends an appropriation of $561 (an increase of $7 million) for the Title V Block Grant in FY 1990. As you know, legislation also is pending to increase the authorization for this program by $100 million. We hope the Subcommittee can fund this effort as well.

- **Community Health Center/Infant Mortality Initiative:** CDF recommends an FY 1990 appropriation of $67 million for the Community Health Center/Infant Mortality Initiative. This $47 million increase will address our nation's shameful infant mortality rate by ensuring infant mortality projects in all community health centers.
- **Jobs Corps:** CDF recommends an appropriation of $950 million (a $209 million increase) for FY 1990. We must reach more highly disadvantaged young people with the basic education, vocational training and support that is so effective in increasing their rates of school completion, employment and earnings.
- **Job Training Partnership Act:** CDF recommends fully funding the new authorization of a separate youth title under JTPA.

The question before this Subcommittee -- and before our nation -- is not whether we can afford to reorder our national priorities, but whether we can afford not to.

The Senate Budget Committee already has placed highest priority on the programs under this Subcommittee's jurisdiction. In past years, this Subcommittee has followed the dictates of common sense to champion additional investments in the programs that prevent dependency and promote self-sufficiency. We urge you to, once again, show the leadership and take the action necessary to save our children and our own future.

Senator **Harkin**. Thank you very much. President Bush's budget increased Head Start by about $250 million. It was the single largest increase, if I am not mistaken, in any of the items in our subcommittee.

Would you say that he made a statement that there were 95,000 that needed to be served, and you do not think that this increase will serve those extra 95,000?

Ms. **Bourdette**. That did not take into account an inflation adjustment for the program of approximately a little over $50 million. So, you would need, in addition to the $250 million, an amount to cover inflation for the program.

That is what the Senate Labor Committee has recommended in its authorization legislation, which is attached to S. 5, and that is what has been passed overwhelmingly by the House, a $317 million increase. That would be required to fund 95,000 additional children, yes.

Senator **Harkin**. OK. Thank you very much. We appreciate it.

Ms. **Bourdette**. Thank you.

STATEMENT OF DAVID L. LEVY, PRESIDENT, NATIONAL COUNCIL FOR CHILDREN'S RIGHTS

Senator **Harkin**. Next, David Levy, National Council for Children's Rights.

Mr. **Levy**. Hello, Mr. Chairman. I am David Levy, an attorney and president of the National Council for Children's Rights.

We urge the funding of section 504 of the Family Support Act, one of the model demonstration projects. Our national council has a nationally prominent advisory panel, including "Dear Abby", Senator Dennis DeConcini, and Norman Cousins. Two of our American University semester in Washington college student interns are here today, Eileen Morrissey and Lee Chala.

Senator **Harkin**. Glad to have them here.

Mr. **Levy**. Thank you, Senator. We work to assure a child the right of two parents, regardless of the parents' marital situation. We publish various written reports, audio cassettes. We have an annual conference.

We appreciate the authorization of $8 million in the act for demonstration projects for 1990–91. We urge the funding of a very modest $4 million for 1990 for several reasons.

One, we must end the era of forced-away fathers. Congress has widely recognized we should not force fathers out of the home in order for poor parents to collect welfare when the parents are together. But when they are not together, there is nothing in this act that would encourage fathers and mothers to stick around other than this very modest $4 million.

The system needs balance. The Federal Government spends more than $1 billion a year on child support collections. Yet, welfare professionals and others say that even with improvements the system may never work quite right, especially in difficult interstate cases.

It is time to supplement what we are doing with a balanced approach. Again a modest $4 million.

Staff 800 numbers and ombudsmen are needed to acquaint parents with their rights and how to proceed and how to resolve informally out of court so the kids are not in the middle of protracted battles.

Last year Congressmen Downey and Brown gave Michigan—Michigan got the only A-plus for its child support collections. Officials in Michigan, such as Debbie Stabenow in the Michigan House, credit Michigan's balanced staff system with the fact that Michigan collects more per administrative dollar than any other State. They collect $8.33 per administrative dollar than any other State.

Prince Georges County, MD, where we got the county to hire the first such staffer east of Michigan, reports an 80-percent success rate. I urge you to look into Prince Georges County. We have figures in our testimony.

Single parents do all they can for their kids. Many kids of single-parent homes turn out just fine. But statistically, such kids are more at risk than where there are two active parents.

We often hear of child support horror stories but not visitation horror stories. There are 250 groups across the country which can tell you some of those horror stories, including Dick Woods in Iowa, Mr. Chairman, who is very concerned about the appropriation of this $4 million.

We not only ask for this $4 million, but that it be funded as a line item. The Child Support Administration of HHS has not been too friendly to noncustodial parents or access questions. They canceled a report showing that fathers pay up to 40 percent more in child support than we had heretofore been led to believe.

This was a report by the prestigious Urban Institute. We got it under a FOIA request. They canceled it because of supposed lack of funding, even though Robert Helms, a high official in HHS, said that his department would be glad to fund this to continue Urban Institute's research into the other 48 States which had not yet been researched.

Robert Helms said this report not only brought out higher figures, but brought out key figures on how to avoid welfare dependency in many cases, data that was nowhere available to the States.

We urge you to please get this report available and funded.

PREPARED STATEMENT

I have abbreviated my comments so much that I beat the light. But may I respectfully urge that this is a modest amount, only $4 million—a small amount which will send a positive signal that we value incentives for two parents to remain involved with their children.

Thank you, sir.

[The statement follows:]

STATEMENT OF DAVID L. LEVY

Chairman Harkin, and Members of the Subcommittee, we appreciate the invitation to appear before you today.

Our National Council for Children's Rights (NCCR) urges the funding of Section 504 of the Family Support Act, to provide for access (visitation) demonstration projects in the states.

We have a nationally prominent Advisory Panel, including "Dear Abby" (Abigail Van Buren), U.S. Senator Dennis DeConcini (D-AZ), and Norman Cousins, who has written on the relationship between health and family.

NCCR works to assure a child the right to two parents, regardless of the parents' marital status. We publish more than 25 written reports, audio/video cassettes, legal briefs and children's materials on: the crisis in family law; evaluation of sole and joint custody studies; anti-kidnapping report; Banana Splits (a school based program to help children at risk), and other family topics.

We hold an annual conference in the Washington, D.C. area, file briefs in state and federal court, including the U.S. Supreme Court, and present annual Chief Justice Warren E. Burger "Healer" awards to lawyers and judges who promote healing, not just litigation.

We appreciate Congress's authorization of $8 million in Section 504 last year, half of which is to be spent in each of the fiscal years 1990 and 1991.

We urge the funding of $4 million for Fiscal Year 1990 for the following reasons:

1. We should end the era of Forced Away Fathers. Congress has wisely recognized that we should not force fathers out of the house in order for poor parents to collect welfare. But we must realize that fathers can be forced away after the marital break-up, as well. There are no incentives in the Family Support System to encourage a child's right two parents after marital breakup other than the $4 million in Section 504. It is a modest amount to spend on behalf of children. Please appropriate it.

2. The system needs balance. The Federal Government spends more than $1 billion a year for child support enforcement, but not a dime for the other side of the coin--access (visitation). Yet we are told that the Child Support Enforcement program has many problems, and some experts say that even with the tightening of penalties and procedures, there will continue to be problems, especially in the difficult interstate cases. It is time to supplement what we are doing with a balanced approach. Section 504 provides the seed money for that balanced new approach.

3. Staff, "800" numbers and obudsmen are needed. We have child support staff in every county and state in the country, to resolve support problems out of court, with a variety of weapons, including wage withholding, liens and interception of tax returns, to enforce support. But we have no informal means to resolve problems relating to court-ordered access. We appreciate Congress's adopting our suggestion to use the word "access" rather than visitation, because parents are not mere visitors in their children's lives, and access focuses on the child's right, as well. The only state with balanced state-wide staff is Michigan's "Friend of the Court." Michigan officials, such

as Debbie Stabenow, chair of the Mental Health Committee of the Michigan House, and Dee Van Horn, acting director of the "Friend of the Court" Bureau in Lansing, credit Michigan's balanced staff system, and balanced state legislation, with the fact that Michigan collects more child support per administrative dollar than any other state. HHS reports that Michigan collects $8.33 for every administrative dollar spent to collect.

4. Prince George's County has proven access enforcement can work. Prince George's County, Maryland, a suburb of Washington, D.C., is the only county east of Michigan to have a full-time access (visitation) staffer. In 1986, after the first full year of operation, county officials reported an 80% success rate in resolving visitation problems, at an average time of 1 hour 37 minutes per case, at an average salary cost of $15 per case. Funding was cut for this position in 1987-88, but we are assured by County officials that the position will again be funded full-time in Prince George's County after July 1, 1989. The Prince George's County Civic Federation has announced it will give our National Council for Children's Rights a "Citizen's Award for Achievement" on June 1, 1989, for our role in the establishment, and re-establishment of this full time position.

Barbara Bush recently said that people are going to have to re-evaluate their lives and put their children first. She acknowledged that poverty, drugs and illiteracy are interconnected with some children's lack of direction. We would add that the problem is especially acute with divorce. Single parents do all they can for their children, but they need help. In too many families of separation and divorce, including unwed families, there is one overinvolved parent, and one underinvolved parent. This imbalance is not good for the child.

We often hear of child support horror stories, yet few of us hear of the access horror stories.

For any members of this Committee who doubt that horror stories exist regarding access, I invite you to any of the 250 support groups across the country, including groups which meet in the Washington area in Arlington, Montgomery/Prince George's County, and Baltimore, to hear the anguish of parents, most of whom are fathers, but some of whom are mothers, and grandparents, who have an enormously difficult time in getting to see their children and grandchildren.

There are access (visitation) problems in up to 50% of all custody dispositions, according to research by Wallerstein and Kelly; Heatherington, Cox and Cox, and other researchers. We need to pay attention to these problems, and try to resolve them. The result will not only be improvements in parenting, but improved child support collections, as well. For where the parents are around, so are their wallets. Studies show that involved parents contribute more money in child support to their ex-wives, and also spend more money directly on the child.

Both Republicans and Democrats agree there is a mountain of research showing that two parents are generally better than one. There are many exceptions, but children with two parents are generally less at risk. Single parents do all they can for their children, but they need help.

Section 504 would give them, and children, that help.

We ask not only that this $4 million be funded, but that it be a line item, so that HHS cannot spend it on any purpose other than improvement of access.

The Child Support Administration of HHS has not been too friendly to access and non-custodial parents in the past. I could cite several examples, but the most recent is the HHS decision to cancel funding of a report that showed fathers pay up to 40% more child support than Congress and the public has been previously led to believe they pay, and HHS's hiding of this report. We obtained it under a F.O.I.A. request.

HHS asked the prestigious Urban Institute to determine payment patterns nationwide. After surveying two states, Florida and Ohio, and finding up to 40% more child support paid by fathers than mothers said they were receiving, HHS cancelled the study. You can find details on the front page of our January, 1989 newsletter "Speak our for Children," copies of which I have attached to this testimony.

HHS said they were cancelling the study for lack of funds. Yet Robert H. Helms, assistant secretary of HHS for Planning and Evaluation, wrote on October 1, 1986 to Wayne Stanton, then administrator, Family Support Administration, whose office handles the Child Support Office, criticizing Stanton for withholding funding to complete the research.

Helms said his office would have been willing to underwrite the "majority of the costs" of continuing the survey. Helms said a nationwide survey would have developed more complete data about subjects "currently nowhere available" including the:

* relationship between support receipts and work behavior in helping families get off welfare

* effect of child support in preventing initial welfare dependence, or

* child support collection potential based on employment and earnings of the absent parents.

We urge this Committee to obtain the report, release it to the public, and recommend that it be completed.

Conclusion

We appreciate Congress's authorization of $4 million for FY90 for access (visitation) demonstration projects. We ask that this money be funded by Congress. $4 million is a relatively small price to pay to address a critical aspect of the support problem that up to now has received no federal funding at all--access (visitation) problems. The U.S. has staff to resolve support problems out of court, but no staff to resolve access problems. Yet the one state that has staff to address both support and access problems (Michigan) is the only state that Congressmen Downey and Hank Brown gave an A plus to on their report card to Congress in October, 1988 on child support. Let's let other states test access projects, too.

Thank you.

Senator HARKIN. The $4 million which you ask for is simply for access or visitation?

Mr. LEVY. Yes, sir; in the bill, section 504, says the States may apply for funds to experiment with access demonstration projects. We appreciate Congress using the words "we recommend access" because noncustodial parents are not mere visitors in their children's lives, and access focuses on the child's right.

The States could hire staff, they could have an ombudsman. They could have 800 numbers. They could have flyers telling parents what—I hope I am answering your question.

Senator HARKIN. This is a demonstration program to provide more access of fathers to their children?

Mr. LEVY. Well, how it works in Michigan—no, not just fathers, sir. In Michigan and Prince Georges County, either parent may file a complaint.

If the noncustodial parent is not showing up or showing up improperly, the custodial parent could file the request. If a noncustodial parent is showing up but the children are not ready, he could file a complaint.

How it works in Prince Georges County is that staffer then calls the other parent and says there is a visitation order here, we need to make this work. Just by making that phone call, in Prince Georges County they found an 80-percent success rate and an average settlement time of 1 hour and 37 minutes, and average salary cost per case, $15.

Just having someone in authority know that access is being taken seriously——

Senator **Harkin**. Right.

Mr. **Levy** [continuing]. Sends a powerful signal.

Senator **Harkin**. You are asking that this be line-itemed?

Mr. **Levy**. Yes, sir; because we think HHS, given its past record, may not fund the money for the access projects. Given their record in concealing this report, canceling this report, and several other things I could cite to you if time permitted.

Senator **Harkin**. I see. This is a new program?

Mr. **Levy**. Yes, sir.

Senator **Harkin**. I would like for you to get me some more information. You said that Michigan collects more child support per administrative dollar than any other State. Can you get me some more information on how they do that?

Mr. **Levy**. I would be glad to.

Senator **Harkin**. You only have a small paragraph here in your testimony.

Mr. **Levy**. I would be glad to.

Senator **Harkin**. Would you get that to my staff, please.

Mr. **Levy**. Certainly, sir.

Senator **Harkin**. Thank you very much. I would like to find out what they can do.

Mr. **Levy**. Thank you, Mr. Chairman.

Senator **Harkin**. Thanks, David.

STATEMENT OF EUGENIA BOGGUS, PRESIDENT, NATIONAL HEAD START ASSOCIATION

Senator **Harkin**. Next, Eugenia Boggus, National Head Start Association. Sorry if I mispronounced the name.

Ms. **Boggus**. Mr. Chairmen and other distinguished members, I am pleased to be here today to testify before this committee that has supported Head Start throughout the years.

I represent 450,000 children and their parents, 80,000 staff, and over 3,900 programs that make up Head Start. As a former Head Start parent, I am also speaking on behalf of 11 million children and their families who have participated in the Head Start program.

We all know that Head Start is a proven program that the Congress has supported for over two decades. We know there is a long-term investment in Head Start and there is confidence in Head Start. We also are aware that there is widespread bipartisan agreement of the value of Head Start. But today Head Start only serves 18 percent of the eligible children.

President Bush has promised a Head Start experience for every eligible child. As a former Head Start parent who did have some children that could not get into the Head Start program and had to remain on a waiting list, that is a wonderful promise indeed.

Former Presidents Carter and Ford, as well as the Council for Economic Development, have called for full funding of Head Start to reach all eligible children. In calling for this full funding, the former Presidents, Carter and Ford, declared spending money for these young Americans is not wasteful; it is wasteful not to invest. We understand the budget constraints, but we believe that it would be imprudent to delay any longer.

Considering current concerns about school dropouts, substance abuse, child abuse and its long-term effects, America's competitiveness in global markets, and the need for a trained work force in the 21st century, the need to provide Head Start services to all eligible children and families is apparent and urgent.

I want to talk about the need to increase the funding to expand services to reach additional children and families eligible for Head Start, and to improve Head Start staff salaries in order to insure high-quality services and the need for funding to meet the new regulations.

The National Head Start Association believes that the $317 million in additional funding in 1990 would be a significant first step toward the goal of full funding.

Increased funding for Head Start could be used in many ways, but there are three particular ones that seem very important.

Funding certainly is needed to increase the number of children served by Head Start. President Bush has asked for $250 million to provide for expansion. Head Start has been a model program. It serves children and families well, but less than one-fifth of the eligible children can be served with the current funding.

As we move toward increasing the number of children served by Head Start, it is important to recognize that some funds must be provided to strengthen the existing Head Start program. While both enrollment and funding have increased in 1980, funding has not met inflation. The net loss of Head Start to inflation has been 5.6 percent, which is a loss of over $69 million in 1989.

In order to maintain services, Head Start salaries have been kept low, which means it is difficult to hire and keep well-trained staff. Therefore, funding to increase salaries and grant basic benefits such as health insurance and retirement, is now a critical need.

Many Head Start programs are on the brink of crisis because of these low salaries, and lose their staff. There are a lot of statistics in the report about the comparisons between a Head Start teacher and a public school teacher. We know the Head Start teachers at this standing make $12,023 a year, and in the public school system they would make higher.

Because of these salaries, we lose our teachers who are trained within the program. We train them and then other programs pick them up. We lose them that way.

These low salaries create critical problems for Head Start staff, but they also place the Nation's main program for at-risk children and families in jeopardy. The problems confronting today's children and families in jeopardy are greater than ever before.

We would like to ask this committee—we are asking this subcommittee to appropriate the full $317 million additional funding. This amount would allow for full funding. President Bush requested $250 million for expansion, which would increase Head Start enrollment by 87,500 3-, 4-, and 5-year-olds, the largest enrollment increase in 20 years.

We urge the subcommittee to include a salary set-aside to increase salaries and benefits, which will help to insure a qualified staff.

In addition, the appropriation would include the $15 million to implement the new regulations to strengthen program quality. This appropriation will also strengthen existing Head Start services and provide a firm foundation for future expansion.

PREPARED STATEMENT

We thank you for the many years that you have appropriated money for Head Start. We thank the President for his request for $250 million for expansion. Head Start works for children and parents and is a comprehensive program that deserves a full and expanded support.

Thank you, Mr. Chairman.

[The statement follows:]

STATEMENT OF EUGENIA BOGGUS

Mr. Chairman, and other distinguished members, I am pleased to be here to testify before a committee that has supported Head Start throughout the years. I am Eugenia Boggus, President of the National Head Start Association. I represent the 450,000 children and their parents, 80,000 staff and over 3,900 programs that make up Head Start. As a former Head Start parent, I am also speaking on behalf of the over 11 million children and their families who have participated in Head Start over the years.

Head Start is a proven program that Congress has supported for over two decades. There is a long-term investment in Head Start. There is confidence in Head Start. There is widespread bipartisan agreement of the value of Head Start. Yet, today Head Start reaches only 18% of eligible children. Presidential candidate Bush promised a Head Start experience for every eligible child. As a former Head Start parent who had a child on the waiting list until he was too old to get into Head Start, that sounds to me like a wonderful promise. Recently, former Presidents Carter and Ford, as well as the Council for Economic Development, have called for full funding of Head Start to reach all eligible children.

In calling for full funding of the Head Start program, former Presidents Carter and Ford declared "spending money for these young Americans is not wasteful; it is wasteful not to invest. We understand the budget constraints, but we believe that it would be imprudent to delay any longer." Considering current concerns about school dropouts, substance abuse, child abuse and its long-term effects, America's competitiveness in global markets, and the need for a trained workforce in the 21st century, the need to provide Head Start services to all eligible children and families is apparent and urgent.

Today I want to speak with you about the need to increase funding to expand services to reach additional children and families eligible for Head Start; the need to improve Head Start staff salaries in order to insure high-quality services, and the need for funding to meet the new regulations.

The National Head Start Association believes that $317 million in additional funding in 1990 would be a significant first step toward the goal of full funding. Increases in funding for Head Start could be used in many ways, but three seem particularly important. First, funding certainly is needed to increase the number of children served by Head Start. President Bush has asked for $250 million to provide for expansion. Head Start has been a model program. It serves children and families well, but less than one-fifth of the eligible children can be served with current funding.

However, as we move toward increasing the number of children served by Head Start, it is important to recognize that some funds must be provided to strengthen the existing Head Start Program. While both enrollment and funding have increased since 1980, funding has not matched inflation. The net loss of Head Start to inflation has been 5.6%, which is a loss of over $69 million in 1989. In order to maintain services, Head Start salaries have been kept low, which means it is difficult to hire and keep well-trained staff.

Therefore, second, funding to increase salaries and grant basic benefits such as health insurance and retirement, is now a critical need. Many Head Start programs are on the brink of a crisis because of low salaries. In 1988, a nationwide salary study done by the Head Start Bureau showed that the average annual salary of a Head Start teacher was $12,023 per year. According to the study, a Head Start teacher with a B.A. degree will make $12,216 a year while a preschool teacher with the same degree working in a public school will make $17,272 a year. For many Head Start staff, the low salaries make survival a struggle. Fifty percent of all Head Start staff earn $10,000 a year or less. The average salary of a Teacher Aide in Region IV, for example, is only $4.80 an hour and they do not work a full year. Their annual salary leaves them below the federal poverty guideline for a family of two.

Because of their low salaries, Head Start teachers who are trained within the program or teachers hired with degrees who acquire some experience are often hired by other programs. This process causes frequent staff turn-over, which hurts the children served by Head Start. Frequent staff changes make children wonder if they did something wrong, when really the teacher needed a job that paid enough to help get her own family above the poverty level and that provided essential benefits such as health insurance. Because of the many facets of the Head Start Program and the multiple problems of the children and parents, Head Start teachers are expected to provide more comprehensive care and carry more responsibility than teachers in preschool programs for more affluent families--but at a much smaller salary. The same problem, of course, exists for other staff.

The low salaries create critical problems for Head Start staff, but they also place our nation's main program for "at risk" children and families in jeopardy. The problems confronting today's children and families are greater than ever before, and Head Start staff must have the skills and training to address those problems. However, the low salaries in Head Start today will make it increasingly difficult to retain and recruit staff with the needed skills. Without specific initiatives to improve salaries in Head Start, children who most need the comprehensive, high-quality preschool experience that Head Start can provide will suffer. The people who work for Head Start have never done so because of the high wages, but they must be paid living wages. Because salaries are such a critical issue in Head Start today, we urge you to include a "set-aside" for salaries.

The $317 million in additional funding would also allow for the $15 million dollars estimated by the Department of Health and Human Services as the cost of implementing the new regulations written to help strengthen program quality. However, since one of the strengths of Head Start has been the ability to adapt to local needs, we do want local option to remain.

We are looking to this committee to provide us with the expansion and strength we need. The success of Head Start has been due to its comprehensiveness, diversified delivery system, local control, and--most of all--parent involvement.

It is hard for me to talk about Head Start without sharing some of my own experiences. I am just one of many examples of how the Head Start program has helped children and their families. I married at 16, then had seven children. I had four children before I heard about Head Start. When my fifth child was four, I tried to get him into Head Start, but there were no slots. Even though he was blind, his name went on a long waiting list, and he never got into the program. There were no other complete, affordable, preschool programs available. I could not work because I had no place to leave my children, especially my son.

My last two children did attend Head Start. There was a lot of difference between them and my older children. My first children went to school with no confidence, but the children who went to Head Start began school with confidence and expected to do well. I am proud to say that my youngest daughter is an all-"A" Honor Roll student. Head Start provided sound, comprehensive, services, which gave her a good beginning. It gave her feelings of success, increased her self-esteem, and made her think she couldsucceed in competitive situations. She still faces challenges with confidence.

What can this Appropriations subcommittee do for Head Start? The Association is asking this subcommittee to appropriate the full $317 million in additional funding. This amount would allow for full funding of President Bush's requested $250 million for expansion, which would increase Head Start enrollment by 87,500 three-, four- and five-year-old children, the largest enrollment increase in twenty years. We urge the subcommittee to include a salary set aside to increase salaries and benefits, which will help to assure a qualified staff. In addition, the appropriation would include the $15 million needed to implement the new regulations to strengthen program quality. This appropriation would also strengthen existing Head Start services and provide a firm foundation for future expansion. We thank you for the many years that you have appropriated money for Head Start. We thank the President for his request for $250 million for expansion. Head Start works for children and for parents. It is a comprehensive program. It is a proven program. It deserves full and expanded support.

Senator HARKIN. Eugenia, thank you much.

You are asking for $317 million a year?

Ms. BOGGUS. Yes, sir.

Senator HARKIN. That is another $67 million more than what President Bush asked for. Let me just tell you that—you are right—Head Start has proven itself over the years. It is 20 years old now?

Ms. BOGGUS. 24.

Senator HARKIN. 24 years old.

Ms. BOGGUS. Our anniversary is next year.

Senator HARKIN. Pardon?

Ms. BOGGUS. Our anniversary is next year, in 1990.

Senator HARKIN. 25th anniversary?

Ms. BOGGUS. Yes, sir.

Senator HARKIN. We have seen all of the data provided. It is well-supported and I think it is good that President Bush asked for the biggest increase in Head Start. We will see what we can do about getting the remainding amount.

Ms. BOGGUS. Thank you, sir.

Senator **Harkin**. Thank you very much.

STATEMENT OF ERNEST G. GREEN, VICE PRESIDENT, MARCH OF DIMES BIRTH DEFECTS FOUNDATION

Senator **Harkin**. Next is Ernest Green, representing the March of Dimes Birth Defects Foundation.

Mr. **Green**. Thank you very much, Mr. Chairman. I am Ernie Green, Vice Chairman of the March of Dimes Birth Defects Foundation, National Board of Trustees.

This morning I would like to share with you the views of the March of Dimes Birth Defects Foundation on Federal funding for health research and preventive health services.

The March of Dimes, as you know, works to prevent birth defects and related problems of low birth weight and infant death. One way in which the foundation pursues its mission is by funding biomedical research to help us understand human development and the causes and treatment of birth defects, low birth weight, and preterm delivery.

For the March of Dimes, prevention also means ensuring access to health care for pregnant women and infants through educational and community services programs. Given the limited impact that any one organization can have in this area, the March of Dimes is a strong advocate for Federal funding of biomedical research and for Federal and State funding for preventive health care for mothers and children.

As a nation, we must make prevention our top priority. Our fiscal constraints demand that we spend money wisely and effectively. Biomedical research and cost-effective health care programs for mothers and children should be top funding priorities for Congress.

We know that every $1 spent on prenatal care can save over $3 in neonatal intensive care costs. We know that each $1 spent on immunization for children saves $10 by preventing diseases. We need to ensure that these effective programs are available to all.

On health research, I would like to concentrate for 1 minute on biomedical research that could help prevent birth defects and improve maternal and infant health.

The Nation's primary source for funding for research on maternal and child health is the National Institute of Child Health and Human Development.

When NICHD was added to the National Institutes of Health in 1962, the Nation's infant mortality rate was 25.3 per 1,000. Technology, developed through NICHD and other sources, has been largely responsible for reducing our infant mortality rate in 1986 to 10.4 per 1,000. This is an important decline, but we still rank 18th among industrialized nations in preventing infant death.

Like the March of Dimes, NICHD is concentrating on reducing low birth weight as a way to reduce the incidence of infant death and disability. One important component of the NICHD program is research carried on by the PERC's, Prenatal Emphasis Research Centers. There are six of these, which focus on high-risk pregnancies.

Adequate funding is essential if we are to make progress in understanding and preventing birth defects and infant mortality. Yet, NICHD was able to fund only 25 percent of the approved grants in fiscal year 1989, and maintaining even these numbers meant that each award had to be reduced by 10 to 13 percent of recommended funding.

The fiscal year 1990 administration budget would fund only 20 percent of the approved grants and cause a further reduction in awards. Similar funding for PERC's is being reduced by 14 percent, and by an estimated 17.5 percent in fiscal year 1990.

On health services I would like to stress a number of areas. The importance of prenatal care and child health care to insuring the productivity of our next generation has been recognized by congressional leaders and such diverse business groups as the Committee for Economic Development.

As I go through this, a number of discretionary health programs are working together to improve maternal and child care. Community health centers provided prenatal care to more than 150,000 pregnant women in 1987. Funding from the maternal and child health block grant was used to serve an additional 400,000 pregnant women, and the Childhood Immunization Program helps fund vaccinations for one-half of our children, and serves all families by monitoring vaccine use as well as incidence of disease by maintaining a vaccine stockpile.

In closing, I would like to go through our summaries. One is that the March of Dimes is deeply concerned about the effects of substance abuse on women and their children. Substance abuse during pregnancy can lead to spontaneous abortion, preterm delivery, birth defects, and impaired brain function and intelligence.

In fact, in New York City the incidence of low birth weight actually rose significantly between 1984 and 1987. A decade of progress was lost in 3 years. We are seeing some 15,000 babies exposed to illicit drugs—most commonly cocaine—before birth.

PREPARED STATEMENT

Our summary recommendations are funding the NIH at $8.4 billion; the National Institute of Child Health and Human Development at $584.6 million; full funding of the maternal and child health block grant; an additional $42.8 million in funding for the Childhood Immunization Program; an additional $70 million for the community and migrant health centers; $162 million for scholarship and loan programs of the National Health Services Corporation; increased funding for the Office of Substance Abuse Prevention, the model prevention, education and treatment programs for substance abusing pregnant women; $12 million to implement the Abandoned Infants Assistance Act, which will provide foster care for drug addicted and HIV-positive infants who are abandoned in hospitals; and $30 million for the pediatric AIDS health care demonstration grants.

Thank you very much, Mr. Chairman, for allowing me to make these remarks.

Senator **Harkin**. OK. Thank you very much, Mr. Green, for your testimony.

Let me just say that the March of Dimes does a great job.

Mr. **Green**. Thank you, your Honor.

[The statement follows:]

STATEMENT OF ERNEST G. GREEN

Good morning. I am Ernie Green, vice chairman of the March of Dimes Birth Defects Foundation National Board of Trustees. This morning, I'd like to share with you the views of the March of Dimes Birth Defects Foundation on federal funding for health research and preventive health services.

The March of Dimes works to prevent birth defects, and the related problems of low birthweight and infant death. One way in which the foundation pursues its mission is by funding biomedical research to help us understand human development and the causes and treatment of birth defects, low birthweight, and pre-term delivery.

For the March of Dimes, prevention also means ensuring access to health care for pregnant women and infants through educational and community service programs. Given the limited impact that any one organization can have in this area, the March of Dimes is a strong advocate for federal funding of biomedical research and for federal and state funding for preventive health care for mothers and children.

As a nation, we must make prevention our top priority. Our fiscal constraints demand that we spend money wisely and effectively. Biomedical research and cost-effective health care programs for mothers and children should be top funding priorities for Congress. We know that every dollar spent on prenatal care can save over three dollars in neonatal intensive care costs. We know that each dollar spent on immunizations for children saves ten dollars by preventing disease. We need to ensure that these effective programs are available to all

HEALTH RESEARCH

Let's concentrate for a minute on biomedical research that can help prevent birth defects and improve maternal and infant health. The nation's primary source of funding for research on maternal and child health is the National Institute of Child Health and Human Development (NICHD). When NICHD was added to the National Institutes of Health in 1962, the nation's infant mortality rate was 25.3 per thousand. Medical technology developed through NICHD and other sources has been largely responsible for reducing our infant mortality rate in 1986 to 10.4 per thousand. This is an important decline, but we still rank 18th among industrialized nations in preventing infant death.

Like the March of Dimes, NICHD is concentrating on reducing low birthweight as a way to reduce the incidence of infant death and disability. One important component of the NICHD program is research carried on by the Perinatal Emphasis Research Centers or PERCs. There are six PERCs, each of which focuses on a different area of perinatal research. High-risk pregnancy, premature labor and birth, and AIDS are among the research areas.

Adequate funding is essential if we are to make further progress in understanding and preventing birth defects and infant mortality. Yet NICHD was able to fund only 25 percent of its approved grants in FY89. Maintaining even this number of grants meant that each award had to be reduced by 10 to 13 percent of recommended funding. The FY90 Administration budget would fund only 20 percent of approved grants, and cause a further reduction in awards.

Similarly, funding for PERCs and other research centers is being reduced by 14 percent in FY89 and by an estimated 17.5 percent in FY90. NICHD, and the National Institutes of Health as a whole, must receive increased funding if we are to maintain a top notch biomedical research program.

HEALTH SERVICES

Now I would like to turn your attention to health services for mothers and children. We are seeing progress in our effort to ensure access to health care for mothers and their children.

- The importance of prenatal care and child health care to ensuring the productivity of our next generation has been recognized by Congressional leaders and such diverse groups as the Council on Competitiveness, the Committee for Economic Development, the American Agenda, the National Commission to Prevent Infant Mortality and the Institute of Medicine.

- The Alan Guttmacher Institute estimates that 361,000 newly eligible infants and pregnant women will be covered by Medicaid in 1990 as a result of recent expansions.

- This year President Bush proposed further expansion of Medicaid and childhood immunizations as steps to improve access to health care services for women and children.

Yet as we reflect on our success in expanding Medicaid and discretionary health programs, we must resist the temptation to become complacent. A sustained commitment to preventive health care is needed to reach the nine million women of reproductive age and twelve million children who remain uninsured. A sustained commitment is needed to combat new threats to maternal and infant health.

A number of discretionary health programs work together to improve maternal and child health. Community health centers provided prenatal care to more than 150,000 pregnant women in 1987. Funding from the Maternal and Child Health Block Grant was used to serve an additional 400,000 pregnant women. The Childhood Immunization Program helps fund vaccination of half of our children and serves all families by monitoring vaccine use as well as incidence of disease and by maintaining a vaccine stockpile. Health professionals, funded through the National Health Services Corps, staff clinics in underserved areas. These programs, plus Medicaid and the WIC food program, which are not funded by this subcommittee, are interrelated and serve the same populations. Thus no one program can be increased at another's expense. All must be fully funded to maximize their ability not only to complement one another, but also to maintain and improve maternal and child health in this country.

At the same time, our success in improving maternal and child health is being threatened, particularly by substance abuse and AIDS. We must strengthen our core maternal and child health programs. A growing number of pregnant women continue to use illicit drugs, which threatens the progress we have made in reducing low birthweight. Nationally, it is estimated that each year in the

United States up to 375,000 babies may be affected by in utero exposure to drugs. In New York City, the incidence of low birthweight actually rose significantly between 1984 and 1987. A decade of progress was lost in three years. Fifteen thousand babies were exposed to illicit drugs -- most commonly cocaine -- before birth.

The March of Dimes is deeply concerned about the effects of substance abuse on women and their children. Substance abuse during pregnancy can lead to spontaneous abortion, preterm delivery, birth defects and impaired brain function and intelligence.

Women who use drugs are also at risk for sexually transmitted diseases, including AIDS. By 1991, there will be an estimated 10,000 to 20,000 cases of pediatric AIDS. Three quarters of these children have a parent with AIDS, or at high risk of infection, according to the United States Department of Health and Human Services. The growing number of children with AIDS adds new burdens to the already stretched federal programs, particularly NIH research, community health centers, and Medicaid.

SUMMARY AND RECOMMENDATIONS:

In summary, I would like to emphasize that federally funded programs for mothers and children have been and continue to be effective. However, we must recognize that millions of women and children still lack access to health care. We must continue our commitment to research and health services that benefit our nation's future generation. To this end, the March of Dimes Birth Defects Foundation recommends:

- Funding the National Institutes of Health at $8.4 billion and the National Institute of Child Health and Human Development at $584.6 million.

- Full funding of the Maternal and Child Health Block Grant.

- An additional $42.8 million in funding for the Childhood Immunization Program, to ensure that all children are adequately vaccinated.
- An additional $70 million for the Community and Migrant Health Centers, which would expand the current Infant Mortality initiative.
- $162 million for scholarship and loan programs of the National Health Service Corp.
- Increased funding for the Office of Substance Abuse Prevention for model prevention, education and treatment projects for substance abusing pregnant women.
- $12 million to implement the Abandoned Infants Assistance Act, which will provide foster care for drug addicted and HIV positive infants who are abandoned in hospitals.
- $30 million for pediatric AIDS health care demonstration grants.

Thank you for the opportunity to present the views of the March of Dimes. I would be happy to respond to any questions that the committee may have.

STATEMENT OF DR. MYRON GENEL, PUBLIC POLICY COUNCIL

Senator **HARKIN**. Next is Dr. Myron Genel of the Public Policy Council. This is the American Pediatric Society, Association of Medical Schools, Society for Pediatric Research. Right?

Dr. **GENEL**. That is correct, sir.

Senator **HARKIN**. OK. Welcome to the subcommittee.

Dr. **GENEL**. Mr. Chairman, I am a professor of pediatrics and associate dean at the Yale University School of Medicine. However, I appear today before you on behalf of three pediatric research societies which represent the vast majority of pediatric researchers, faculty of medical and research facilities, and the leadership of all U.S. medical school pediatric departments.

We have submitted written testimony, and I ask that it be entered into the record.

Briefly, we fully support the recommendations of the ad hoc group for medical research funding for fiscal year 1990 of $8.4 billion for the National Institutes of Health, $933 million for the research and training programs of ADAMHA. We also urge continued support for primary care training programs under title 7 of the Public Health Service Act.

Within NIH, we specifically urge continued support for the biomedical research support grants, or BRSG Program, which is a vital source of flexible funds for our research institutions.

We support the recommendation of a $584 million appropriation for the National Institute of Child Health and Human Development.

During the remainder of my time I would like to encourage you to promote development of a new program which we would title the Child Health Research Centers Program within NICHD.

Mr. Chairman, our Nation has developed a number of excellent centers of care for children throughout the Nation. Our members have been at the forefront of this development and provide the professional leadership. I speak of the freestanding children's hospitals and integrated children's centers within our terciary care academic medical centers.

These children's hospitals and pediatric centers provide an unparallel level of clinical care by present day standards. However, they are less and less able in an explosive expansion of medical knowledge to promise that this care can be provided into the next century.

It is important that facilities be provided and support be provided to train the next cadre of pediatric clinical investigators who will be important to translate this knowledge into clinical care.

We recommend development of a modest program during fiscal year 1990. We estimate that $10 million in additional funds will permit NICHD to provide for 15 to 20 such centers.

Mr. Chairman, there have been many major advances in pediatric care just during my relatively short professional career of 25 years. These have included identification and successful treatment, greatly reducing the cost, for treatment of many inborn and genetic errors.

Let me just mention one. Biatinate's deficiency, a disease which results in severe mental retardation, which now can be identified and treated for $22 a year. Congenital hypothyroidism, congenital heart disease, the eradication of RH erythroblastosis.

I could go on and on, but all of these advances have depended upon development of a critical mass of scientific data and then successful application to clinical therapy by pediatric physician scientists.

PREPARED STATEMENT

Mr. Chairman, currently there are only a handful of pediatric centers which are capable of accepting this critical responsibility for information transfer over the next decade. Development of a Child Health Research Center's Program, as I have described, within NICHD will go a long way to addressing this major deficit.

I thank you.

[The statement follows:]

STATEMENT OF DR. MYRON GENEL

I am Dr. Myron Genel, a Professor of Pediatrics a Yale University. I appear before you to represent the American Pediatric Society, the Society for Pediatric Research and the Association of Medical School Pediatric Department Chairmen. These organizations represent pediatric researchers, the faculty of medical and research facilities, and the leaders of all U.S. medical school pediatric departments. My testimony will focus on biomedical and behavioral research and research training supported by the National Institutes of Health and the Alcohol, Drug Abuse and Mental Health Administration and on the training of health professionals.

I RESEARCH AND RESEARCH TRAINING

Each year our organizations come before this subcommittee to ask that you keep uppermost in your minds the needs of our infants, children and adolescents. Our children deserve the chance to be born healthy and to grow and develop into adulthood. Biomedical and behavioral research into all aspects of human development, both normal and abnormal, increase the opportunities for infants, children and adolescents to have this chance.

Today, I would like to specifically address an idea which the pediatric research community feels deserves consideration. In order to build upon opportunities now before us, it would be appropriate for NICHD to have the ability to provide core support to academic and clinical centers whose primary mission is the care of children. This support would enable these centers to build upon existing research and training programs and to branch out into new areas as needed. Many institutions have used private and public funds to develop excellent faculties, facilities and leadership within the pediatric research field, but more could be done. If more institutions had needed core support, they too could attract additional public and private research support which would ensure that research questions about improving the health of children can be examined. Such support would also benefit the training of those pediatricians who wish to enter into the academic and/or scientific career. We urge this subcommittee to recommend to NICHD that it begin a program to support the Child Health Research Centers, which provide this vital core support.

Congress has recognized that the federal government does have the responsibility to support this nation's biomedical and behavioral research program. Unfortunately, the rapid pace of the development of improved technology, the increased costs of using animals and maintaining animal facilities, and many other factors have caused the costs of research to soar. Many institutions have become more conscientious in an effort to trim these costs, and submit grant proposals which contain little financial flexibility. When these grants are reviewed by NIH study sections, they are often reduced before being sent to the councils for final approval. Once a grant is approved, it receives a "negotiated reduction" from the institute to which it has been assigned. Such "negotiated reductions," originally conceived to allow NIH to weather a few lean years, have become the standard operating procedure. It is understandable to trim a proposal to remove any unnecessary costs, but such trimming can only go so far until vital components of a program are seriously affected.

The budget as proposed by the Administration for FY 1990 has the potential to seriously compromise the future of biomedical and behavioral research, especially in pediatrics. The Institute which should be the primary focus for all pediatric research, the National Institute for Child Health and Human Development, has a long list of initiatives which will be affected. Most of these initiatives were set into motion at the request of Congress in the last few years. The following list contains only a few examples of how NICHD would be affected.

- Clinical trials to test antiviral therapies for AIDS will be limited and the behavioral intervention studies in inner city minority populations will undergo a 14 percent funding cut.

* The planned seven or eight projects to develop a definitive diagnostic test for HIV infection in newborns will be reduced to two or three projects. Current methods cannot differentiate truly infected infants from those who merely have antibody from an infected mother.

* Phases II and III of the clinical trials of NICHD's promising pertussis and H flu vaccines will be delayed.

* The injury prevention research five year plan's grant and contract studies planned for next year cannot be started.

* The network to study the psychological and social effects of non-parental infant care will be reduced to roughly half the original level.

Similar examples could be found for the rest of NIH. What is more disturbing and only compounds the problem is that, just as in other areas of health programs, children often are slighted in favor of other, more "popular" areas of research, and this occurs throughout NIH.

Another troublesome area within the research community is how to ensure that there are sufficient researchers for the future. We feel strongly that adequate provision for such training is essential. Beginning several years ago, medical schools, colleges and universities started to "encourage" departments and individuals to become more revenue-producing through the provision of health services. Non-revenue-oriented research projects suffered. We all recognize the value of and need for physician investigators in the clinical setting and clinical research is critical to the eventual use of new technologies in medical practice. However, physician investigators still have a role to play in basic research. Congress must direct adequate funds for the training of our new biomedical and behavioral researchers.

To provide the necessary support for this nation's biomedical and behavioral research program, we recommend Congress adopt the recommendation of the Ad Hoc Group for Medical Research Funding of $8.416 billion for NIH and $933 million for research and training programs at ADAMHA. We support the Friends of NICHD recommendation of $584 million for NICHD.

II PRIMARY CARE TRAINING GRANTS

Once again, the Administration has chosen to eliminate funding for the training of many health professionals. At a time when so many children lack medical attention from a pediatrician, or from any child health care professional, it seems unwise for the Administration to adhere to a policy which appears to state that primary care physician training is not important enough for federal support. The training of pediatricians and other primary care physicians is not one of the more lucrative operations of any institution; pediatric procedures do not bring in the same level of revenue. This does not mean such training is unimportant. It does mean that training facilities need continued assistance from outside sources, and the Title VII primary care training grants, although a relatively small amount, is one of those sources. We urge this subcommittee to support this program at its full authorization level of $23 million.

I thank you for the opportunity to appear before you today.

Senator HARKIN. Doesn't NICHD already have pediatric centers?

Dr. GENEL. They do not. The centers that they have are categorical centers. What we are recommending is provision of funding for a multidisciplinary pediatric center that would cover a broad range of pediatric disease. I think the specific emphasis would, of course, vary depending upon the degree of support at these particular centers of excellence. So, these would be generic rather than categorical.

Senator HARKIN. In your recommendation, would they be incorporated right into the existing centers or would these be new, different centers?

Dr. GENEL. Well, I think there needs to be maximum flexibility, Mr. Chairman. I think that what we are really striving for is a provision of a critical mass of core support that would allow pediatric centers which are providing a vast amount of care to then go the next stage and help nurture and develop critical young investigators for pediatric research.

I think I could describe these as nurturing centers, and I think that would describe the emphasis very well.

Senator **Harkin**. OK. Thank you very much, Doctor.

Dr. **Genel**. Thank you, sir.

STATEMENT OF GINNY CONWAY, CHILDREN'S TASK FORCE OF THE CONSORTIUM FOR CITIZENS WITH DEVELOPMENTAL DISABILITIES

Senator **Harkin**. Next is Ginny Conway, the Children's Task Force of the Consortium for Citizens with Developmental Disabilities.

Ms. Conway, thank you very much for your appearance, and please proceed.

Ms. **Conway**. Thank you for this opportunity to see democracy in action. This is a real thrill for me.

Senator **Harkin**. Where are you from?

Ms. **Conway**. I am from Jenkintown, Montgomery County, PA.

As you said, I represent the Children's Task Force for the Consortium for Citizens with Disabilities. It is a coalition of over 70 national organizations that advocate for persons with disabilities and their families.

My husband and I live in Jenkintown. We have three children. Chuck is age 21, Paul 19, and Andy, who is 16. Andy is severely retarded and he functions at the level of about 1- or 1½-year-old child. He has atastic cerebral palsy and epilepsy. He seizures just about every night in his sleep. During the day Andy attends a secondary level school program for severe and profound mentally retarded students.

I am here today to address a very critical issue, respite care, especially for families who have handicapped children.

Respite care is what allows children to live at home with their families rather than in institutions. Families with children who have disabilities, for them respite care is a necessity, not a luxury. Thousands of families with children with disabilities across this country have only respite care occasionally. It is more of a dream rather than a reality.

My family is one of the lucky ones. In Pennsylvania there is money set aside for respite care, and in Montgomery County we get 8 to 10 hours a month subject to approval by our Office of Mental Retardation if the funding is available.

Usually the funding is so tight that a family does not know from 1 month to the next if their respite will be available. Parents must request their respite 1 month in advance. Last week I had to call and ask for my respite care for Andy for June.

As you can imagine, it is difficult to determine a month in advance what your need will be. Also, it makes dealing with emergencies impossible.

Families in other parts of the country do not even receive this respite care each month. In fiscal year 1988 the mental retardation developmental disability State agencies in Iowa, Kansas, Mississippi, Nebraska, Oklahoma, Oregon, South Dakota, Virginia, and Wyoming did not provide any funding for respite care or family support services.

I cannot imagine how families of children with severe disabilities in these States cope. In Iowa, a family with a moderately retarded and medically fragile teenager had not been able to leave their home for evenings out or weekends away for over 20 years.

Another family struggled for 2 years to develop a respite program in their community. They finally had to resort to placement in a child's interim care facility for the mentally retarded. The strain of the situation resulted in a divorce of the couple and the mother's need for counseling.

Because of their children's disabilities, families cannot hire a neighborhood babysitter, and many do not have extended family to help care for their children. They need qualified trained providers who they trust to care for their child.

My family is fortunate, and my husband and I have the financial resources to periodically pay for private respite care. For many families, this is a staggering expense and the mother is frequently the one who is likely to have the responsibility, and many times they fall below the Federal poverty level.

The stress of caring for a child with a disability is overwhelming. I know of a mother who has a multiply handicapped child who seizures, her husband works long hours because they do not have a good income. Last year she was forced to do her grocery shopping after midnight when her husband came home. She developed high blood pressure and had to receive treatment for it.

Many times marriages break up. I personally know of families where this has happened.

Last year Congress appropriated only $5 million for the Temporary Child Care for Handicapped Children and Crisis Nurseries Act. Only $5 million, and there are nearly 7 million children with disabilities.

Respicare is cost effective. It costs $60,000 a year for a child to be institutionalized. Helping keep their children at home by giving them a minimal amount of respite care will save the Federal Government millions of dollars.

PREPARED STATEMENT

We are asking this year for an appropriation of $20 million for the Temporary Child Care for Handicapped Children and Crisis Nursery Act.

I would rather have you ask me questions than go on with the testimony because it is self-explanatory. Is there anything you would like to ask me?

[The statement follows:]

STATEMENT OF GINNY CONWAY

My name is Ginny Conway. I am representing the Children's Task Force of the Consortium for Citizens with Disabilities, (CCD), a coalition of over 70 national organizations that advocate for persons with disabilities and their families.

My husband and I live in Jenkintown, Pennsylvania, a suburb of Philadelphia. We have three sons, Chuck, age 21, Paul, age 19 and Andy who is 16. Andy is severely retarded -- he functions at the level of a child who is a year to a year and a half old. Andy also has atastic cerebral palsy and epilepsy. He has seizures almost every night in his sleep. During the day Andy attends a secondary level school program for severe/profound MR students.

I am here today to address an issue that is most critical to parents of children with disabilities: respite care. Respite care is typically defined as any type of relief care giving families the opportunity to take a break from caring for their children with disabilities. in 1980, respite care was the need most frequently requested by families of children with developmental disabilities.

Respite can include temporary relief ranging from a few hours of care to intermittent residential care ranging up to a few weeks. This temporary relief may be provided on an emergency basis or on a periodic basis either in the family's home or in out-of-home settings in the family's community.

Respite is what allows children to live at home with their families rather than in institutions. For families of all children with disabilities, respite is a necessity, not a luxury. But unfortunately for thousands of families of children with disabilities across this country, respite care services are only a dream, not a reality.

My family is one of the lucky ones. In Pennsylvania, families like mine are given 10 hours of respite per month, subject to approval by the MR office, if the funding is available. Usually the funding is so tight that a parent doesn't know from one month to the next if their respite will be available. And, parents must request their respite a month in advance -- that is, last week I had to call and ask for respite for specific hours in June. As you can imagine, it is very difficult to determine a month in advance when you will need respite. And it makes dealing with emergencies almost impossible.

However families in other parts of the country don't even receive 10 hours of respite a month. In FY 1988 the MR/DD state agencies in Iowa, Kansas, Mississippi, Nebraska, Oklahoma, Oregon, South Dakota, Virginia and Wyoming didn't provide any funding for respite care or family support services.

I can't imagine how families of children with severe disabilities in these states cope. In Iowa. a family with a moderately retarded and medically fragile teenager has not been able to leave their home for evenings out or weekends away for over 20 year. Another family struggled for two years to develop a respite program in their community. They finally had to resort to placement in a children's ICF/MR. The strain of the situation resulted in a divorce of the couple and the mother's need for counseling.

Because of their children's disabilities, families cannot hire a neighborhood babysitter and many do not have extended family to help care for their children. They need qualified trained providers, who they trust, to care for their children. My family is fortunate in that my husband I have the financial resources to periodically pay for private respite care for Andy. However for most families, private respite is out of the question -- they simply can't afford it. As you know, Mr. Chairman, the correlation between disability and poverty in this country is staggering: a family with a member who has a disability is three times more likely to fall below the federal poverty line than a family with all able-bodied members.

The stress of caring for a child with a disability often can be overwhelming. I know a mother of a child who is multiply handicapped (with profound mental retardation and an active seizure disorder) who is forced to do her grocery shopping at midnight when her husband comes home from work. He has to work long hours to make ends meet. This mother recently developed high blood pressure because of the stress.

Sometimes coping with day to day life becomes impossible for families of children with disabilities. Many marriages break up, which only exacerbates the stress of caretaking for the parent with custody.

It doesn't surprise me that child abuse in families with a child with a disability has reached such alarming proportions. Recently the Seattle (King County, Washington) Child Protective Services Department found that 42% of their child abuse cases involved a child with a developmental disability.

Last year Congress appropriated only five million dollars for the Temporary Child Care for Handicapped Children and Crisis Nurseries

Act — the only federal program that provides funding for respite care services. Only five million dollars! -- for nearly seven million children with disabilities.

I know that the most pressing problem facing the Congress is the enormous federal deficit. However respite care is cost effective. On average it costs over $60,000 per year for a child to be institutionalized. Helping parents keep their children at home, by giving them a minimal amount of respite care will save the federal government millions of dollars every year.

The Consortium for Citizens with Disabilities recommends that Congress appropriate 20 million dollars for the Temporary Child Care for Handicapped Children and Crisis Nurseries Act for FY 1990. This may seem like a large increase to you, Mr. Chairman, but it seems like nothing in comparison to what the Pentagon wastes every year. We have all heard stories of cost overruns in the Pentagon, such as the Air Force ordering coffee pots that cost over $7600 a piece. When I hear those stories I translate those dollars into the amount of respite care that could be purchased -- almost 1400 hours, at the going rate in Pennsylvania. I can't tell you how much even three hundred hours of respite care would mean to a family.

Over the past few years everyone has been talking about the importance of the family. Many Members of Congress have only paid lip service to the tremendous pressures American families, particularly families of children with disabilities, face. Mr. Chairman, you have been among the few who have done much more than pay lip service to us. You have truly been a champion for us and our children.

We realize that you and your colleagues are faced with enormous pressure to fund many vital programs. Please remember that increasing funding for respite care and crisis nurseries by 15 million dollars will dramatically improve the lives of thousands of children with disabilities and their families. Thank you again for your leadership on behalf of my son and all children with disabilities.

Consortium for Citizens with Disabilities: Children's Task Force

AIDS Action Council

American Academy for Child and Adolescent Psychiatry

American Psychological Association

American Association of University Affiliated Programs

American Occupational Therapy Association

Association for Retarded Citizens of the United States

American Speech-Language-Hearing Association

Child Welfare League of America

Epilepsy Foundation of America

Mental Health Law Project

National Association of Protection and Advocacy Systems

National Association of Rehabilitation Facilities

National Head Injury Foundation

National Mental Health Association

The Association for Persons with Severe Handicaps

United Cerebral Palsy Associations, Inc.

Senator HARKIN. As you know Ms. Conway, I wear another hat. I chair the Handicapped Subcommittee for the U.S. Senate. And let me tell you, I have traveled around and met with families all over this country, the one issue that just keeps coming up is the issue of respite care. You have pointed out that it costs $60,000 a year for a child to be institutionalized. But, parents would like to take care of their children.

Ms. CONWAY. That is right.

Senator HARKIN. I do not know if we know the same family in Iowa or not, but I know a family in Iowa—they have not been married 20 years but it is probably approaching that now. But, their story is just heartbreaking. They cannot go out in the evenings. They have never had a vacation. Never been able to take a vacation.

Ms. CONWAY. It is incredible.

Senator HARKIN. They cannot get a babysitter because of the specific needs of their child. They have told me, and I have heard other stories, about marriages that break up because of the stress of this situation. There is just too much stress. The couples cannot handle it.

Ms. CONWAY. And it falls on one parent instead of two.

Senator HARKIN. Then it falls on one parent. Precisely.

Ms. CONWAY. It is incredible. Just taking a walk after dinner. My older boys, they commute to college but they are not home very much—19 and 21 year olds do not hang around. Just taking a walk after dinner, we have to call maybe a neighbor's kid to come in. After Andy is in bed, we will say, "He is asleep. Can we go?" If nobody is home, we do not go for a walk.

We see all these fitness people out there walking and we are sitting there watching the tube because we have no choice. It is very difficult just getting out to eat.

Senator HARKIN. We put $5 million into it last year.

Ms. CONWAY. It is a drop in the bucket considering the numbers. That usually averages—I know in Montgomery County our staff people do not get a lot. It is $5.25 an hour. That is what I pay—when I do not have respite money, we pay it ourselves. If you go out for 4 hours, you are spending $20 just for respite care. Just to go to the mall.

Senator HARKIN. Does the Temporary Child Care for Handicapped Children and Crisis Nurseries Act provide grants to States?

Ms. CONWAY. It provides grants for crisis nurseries. The crisis nurseries are children who are handicapped, who are at risk of child abuse.

That is like closing the barn door after the horses are out. I mean, many families—when I read of a family where there is abuse in the family, many times I wonder, you know, how involved is the child's need.

We have a support group for families in Montgomery County, and the stories—families have said, "Am I going to go over that brink when I read child abuse stories?"

Senator HARKIN. Let me tell you, there will be more than $5 million in that program next year. OK?

Ms. CONWAY. I know that it will be put to good use. Thank you.

Senator HARKIN. It will be more than $5 million. I do not know how much we will get, but there will be more than $5 million. Thank you very much.

Ms. CONWAY. Thank you.

STATEMENT OF DR. MARVIN O. KOLB, AMERICAN ACADEMY OF PEDIATRICS

Senator HARKIN. Dr. Marvin Kolb, American Academy of Pediatrics.

Senator HATFIELD [presiding]. Dr. Kolb, we have had a shift of duty here. A privileged opportunity. I am happy to welcome you and to hear your testimony. I believe that Chairman Harkin has already outlined the general parameters of our procedure here and, therefore, I would invite you to present your testimony at this time.

Dr. KOLB. Thank you, sir. Mr. Chairman and members of the committee, I am Marv Kolb. I am a pediatrician. I am here today representing children of America through the American Academy of Pediatrics.

First of all, I want to take this opportunity to complement you and your sensitivity to the complexity of children's issues by grouping the child advocates together today at this hearing.

We all appreciate the tough decisions facing your committee, but hope that today's organized presentations on programs that impact children will assist the committee in making these difficult decisions.

In my brief oral statements today I would like to highlight two programs. One, the Childhood Immunization Program, and, two, the National Institute of Child Health and Human Development.

Regarding immunizations, the committee is well aware of the cost/benefit ratios of immunizations. Such programs are obviously not free, but clearly fall into the prudent investment category.

For next fiscal year, however, an additional $40 million will be needed. The two big ticket items in this $40 million are $20.5 million to implement the current Measels Outbreak Control Program, and $18.5 million to prevent hepatitis B in infants born to hepatitis-positive moms.

Let me just say a few words on our Nation's measles outbreak. You know, in spite of our country's goal to eliminate measles, we are not accomplishing that. Compared to last year, this year we are going to have over a 280-percent increase in measles cases. Most of these outbreaks are really in preschool children and it is in various States throughout the country.

Measles, Mr. Chairman, is a preventable disease. Yet, American children are unnecessarily suffering side effects as a result of this outbreak, and there have been approximately 10 deaths so far.

This outbreak has caused the public health officials in our country to reassess our current measles policy. A decision on this is going to be forthcoming very soon. It is possible that rather than the one vaccine dose which we now recommend, that that will be increased to two doses. I raise this issue with you now because this increased dosage to two shots will have a significant impact on the new dollars needed.

As for research, I think the academy definitely joins the biomedical research community in supporting increased funds for NIH. But, to carry my prevention theme through, I wish to highlight specifically NICHD. Since this unique institute is not disease-specific, it has been shortchanged in budget allocations. While one does not die or suffer from prevention, in terms of human misery, if you consider it, our Nation's health status would be significantly impaired if it were not for the benefits of the research in the prevention area.

PREPARED STATEMENT

Finally, just a few words about research training centers. We really need and request an additional $10 million specifically allocated for the purpose of supporting young investigators.

Mr. Chairman, on behalf of pediatricians and the children of this country, I thank you for the opportunity of being able to participate here, and would be happy to answer any questions.

[The statement follows:]

STATEMENT OF MARVIN O. KOLB

Mr. Chairman, I am Dr. Marvin O. Kolb, a pediatrician, here today representing the infants, children and adolescents of our country as one of the 37,000 pediatricians of the American Academy of Pediatrics.

As you well know, investing in the numerous child health programs greatly improves the chance for each child to become a healthy, productive adult. Health programs for children range from necessary preventive care, such as the immunization program and prenatal care for pregnant women, to delivery of health services, to biomedical and behavioral research.

Fortunately, most of our children are born healthy and continue to thrive if they have access to and receive the basic preventive services. But far too many of our infants and children die needlessly, or grow up disabled or crippled by disease, injury, abuse and/or a host of other societal problems. Hence any policy that promotes good health will benefit children over their lifetime, but a neglectful course will cause harm and be more costly in the long run.

In the time alloted, let me highlight a few important areas.

CHILDHOOD IMMUNIZATION PROGRAM

The Childhood Immunization Program is the very cornerstone of a child's health and well being and its cost/benefit ratios are well known to this committee. We commend the Administration in its request for adequate funding to purchase these vaccines, but it has failed to recognize the necessary additional costs of program implementation, vaccine supply and the recent measles outbreak across the country.

For Fiscal 1990, we recommend a funding level of $183.7 million for the Childhood Immunization Program. This request simply restores to last year's level the necessary state operational costs, the vaccine stockpile, and federal administrative monies. The "big ticket" items in this request include $20.5 million for the current Measles Outbreak Control program and $18.5 million to prevent hepatitis B in infants born to positive mothers.

The Measles Outbreak Control program became essential with the new recommendations of CDC to control measles outbreaks across the country. These monies would be targeted to high risk areas where it has become necessary to immunize children at a younger age (from 15 down to 9 months) in order to protect them from disease. Such children will require two doses of the vaccine for lifelong immunity.

At this time we must raise the issue that a two-dose regiment may be recommended for all children by CDC during the next fiscal year. This issue is currently under discussion. Should this recommendation go forward, this will have a significant fiscal impact on the program.

Childhood Immunization Program Total Recommendation: $183.7 million

NATIONAL VACCINE PROGRAM

The Academy also supports an additional $3 million for the National Vaccine Program Office and $27.5 million for strengthening vaccine-related programs. While dramatic reductions in vaccine-preventable diseases have occurred, many of the currently achievable goals have not yet been reached and these monies would be directed toward that end.

National Vaccine Program Recommendation: $30.5 million

MATERNAL AND CHILD HEALTH BLOCK GRANT

The Maternal and Child Health Block Grant has been the primary health services program for mothers, infants, and children for more than 50 years. This program was designed to assure mothers, children and adolescents access to quality health care which would protect the children from preventable diseases, encourage behavior that fosters good health, treat the chronic illnesses, reduce infant mortality and morbidity, and help those with special health needs. The block grant is charged to interact with other federal programs affecting mothers and children to focus the often-limited resources, decrease duplication of programs and services, and reduce fragmentation of these programs. This mission is certainly broad, but the program has been successful and deserves to have its authorization level raised to allow it to meet the needs of the population. However, at a minimum, we must request the block grant to be funded at its full authorization level.

Maternal and Child Health Block Grant Recommendation: $561 million

NATIONAL INSTITUTES OF HEALTH

Congress has long recognized the role which biomedical and behavioral research plays in the health of our infants, children and adolescents and has shown its support for the National Institutes of Health and the research program it funds. Various institutes fund research to prevent as well as treat infectious diseases, to prevent birth defects and anomalies through genetic and behavioral patterns, to diagnose and treat children and adolescents with AIDS, and how nutrition affects the health of pregnant women, infants, children and adolescents. This is a very small list of all the activities which could be classified as "pediatric" research.

The core of pediatric research should be funded through the National Institute of Child Health and Human Development since its charge is to be the primary institute focusing on child health and human development. NICHD's history, however, is that it has not received the increases comparable with other institutes, and its negotiated funding reductions are among the highest rates at NIH. Congressionally mandated research areas have been either put on hold or the planned activities have been seriously reduced.

The Academy, in concert with other organizations, requests that this subcommittee consider a need which exists within the pediatric research community. This need is for identifiable centers to be supported by a relatively small grant from NICHD to provide monies to be used for core support and to support young investigators while they develop their careers under the guidance and tutelage of established investigators. These centers would be awarded grants on a competitive basis. We recommend $10 million be allocated to begin this initiative.

NIH Recommendation: $8.416 billion

NICHD Recommendation: $584 million

INJURY CONTROL PROGRAM

Among other important initiatives, the Academy also would submit its strong support for the injury control program of the national Centers for Disease Control. Indeed it is the considered judgment of pediatricians that an appropriation of $50 million for fiscal 1990, combined with a staffing level of 150-55 FTEs, is critical if the United States is to achieve the goals recently outlined in the National Academy of Science report, "Injury in America." This sum would as well provide sufficient resources and staff to allow the CDC administratively to create a "Center" or "Institute" for the injury program within the agency.

Injury Control Program Recommendation: $50 million

EMERGENCY MEDICAL SERVICES

Title III of the Public Health Service Act supports up to four demonstration grants per year for emergency medical services systems for acutely ill or seriously ill children. This important law makes funds available for the development, establishment and operation of regional centers for pediatric emergency services to support training and research activities relating to pediatric medical emergencies.

Accidental injuries are the leading cause of death for children. For this reason, the Academy strongly supports the full appropriation of $4 million for 1990 for demonstration grants, so that the unique needs of children can be adequately addressed in an emergency medical situation.

Pediatric Emergency Medical Services Recommendation: $4 million

PEDIATRIC AIDS

Infants, children and adolescents have not escaped the AIDS epidemic. For Pediatric AIDS activities, we are recommending $150 million for programs to address the biomedical and behavioral research needs, the prevention programs, the delivery of necessary services, and for training and education. For example, NICHD is conducting research into the specific biological mechanism of virus transmission from mother to fetus. The Abandoned Infants Assistance Act passed in 1988 to provide foster care and community placements for these infants needs funds to carry out the mandates of the program. We urge this subcommittee to remember this population when allocating the AIDS monies.

Pediatric AIDS Recommendation: $150 million

CHILD CARE

The Academy continues to be concerned about the availability of safe, quality child care. For this reason we have supported measures which would require uniform health and safety requirements for child care facilities. We request that this subcommittee be prepared to fund a child care program at $620 million for FY 1990.

Child Care Recommendation: $620 million

Senator HATFIELD. Thank you very much, Dr. Kolb. We appreciate what your presence means and what is really translated into your day-to-day activity. It is a great calling you have and I commend you for it, and assure you that you have a very sympathetic ear this morning both in Senator Harkin and myself.

Our efforts will be certainly to maintain not only our levels of service for these various sundry programs identified in this hearing but also to hopefully do the battle on the 302(b) allocations which will ultimately recognize the need to increase our support for these programs.

Thank you very much.

Dr. KOLB. Thank you, sir.

STATEMENT OF DR. CHRISTOPHER A. SQUIER, UNIVERSITY OF IOWA SCHOOL OF DENTISTRY, AMERICAN ASSOCIATION FOR DENTAL RESEARCH

Senator HATFIELD. I would like to invite Dr. Christopher Squier, University of Iowa School of Dentistry, representing the American Association for Dental Research. Good morning.

Mr. SQUIER. Good morning. My name is Christopher Squier. I am assistant dean at the College of Dentistry in Iowa City. My personal research is concerned with diseases of the lining of the mouth, including oral cancer.

I am appearing today on behalf of the American Association for Dental Research [AADR], of which I am a member. We appreciate this opportunity to present testimony on behalf of the National Institute for Dental Research, 1990 budget.

The membership of the AADR consists of over 4,000 scientists in a variety of disciplines whose main object is to study the major causes of disease of the oral cavity and related structures. Despite the magnitude of the challenge, the achievements of dental research have been impressive and we have contributed significantly to the health of the American people and offered important economic benefits in terms of cost savings to the patient and to the population.

For example, there has been a substantial decrease in dental caries, of which I am sure you are aware. This is particularly marked among our children. On the other hand, for older Americans, caries of the exposed parts of the tooth root—that is root caries—is on the increase, and it is about the oral health of the elderly that I would like to talk now.

As you are all aware, the number of older people in our population is increasing. In Iowa, we have one of the largest proportions of elderly in the Nation. Paradoxically, it is often the drugs and the treatment that can control diseases such as cancer and prolong life that bring about distressing oral conditions such as dry mouth, burning sensations and very painful ulcerations, that can make the life of the elderly person very unpleasant.

Fortunately, there are some answers emerging from research to the problems of health of the elderly. We have in Iowa colleagues working on dental implants which can, for those that have lost their natural teeth, provide a firm anchorage of artificial teeth into the jawbone. We are working on treatments for root caries and on artificial salivas that can alleviate a dry mouth.

Nevertheless, there is still a need to learn more about age changes as they affect the oral tissues, and perhaps more important, to apply this knowledge to the patients and to the population. In this respect, I am asking you to support the request by NIDR for $2 million to initiate three clinical research centers which will facilitate the transfer of dental research to the population.

Mr. Chairman, in order to approach the many problems of oral disease that still afflict the American people, we respectfully request a funding level for the National Institute of Dental Research of $171 million in fiscal 1990. This will allow for a balanced program of dental research in which dental schools and research institutions, such as our own, will participate.

Mr. Chairman, this concludes my testimony as it relates to the National Institute for Dental Research, but I would like to take the opportunity to mention one additional program which provides important support for dental research. That is the biomedical research support grant which is being eliminated in the President's budget.

The program is designed to meet emerging opportunities for research and is an important part of the research effort in this country. It is the lifeblood of my own institution.

PREPARED STATEMENT

We believe that the proposed elimination will seriously weaken the health science research effort in this country and we urge the committee to restore this program.

This completes my testimony. I thank you for the opportunity to appear before you. I would be happy to answer any questions.

[The statement follows:]

STATEMENT OF DR. CHRISTOPHER A. SQUIER

Mr. Chairman and members of the Committee, my name is Dr. Christopher A. Squier, and I am Assistant Dean for Research at the University of Iowa School of Dentistry.

I am appearing today on behalf of the American Association for Dental Research (AADR), of which I am a member. The members of the Association appreciate having this opportunity to present testimony regarding the 1990 budget for the National Institute of Dental Research.

The membership of the AADR consists of over 4,000 scientists from a variety of basic science and clinical disciplines located in universities, research institutes, hospitals, and industrial laboratories around the country. Our principal objective is to study the causes of the major diseases affecting the oral/facial region, and to seek ways of treating or preventing these diseases.

Scope of Dental Science

The field of dental research is broad in that it covers a multitude of oral diseases which afflict the mouth, teeth, and jaws. Our goal is to learn how to prevent or control these diseases, so that future generations need not lose a single tooth to disease.

Dental research explores all aspects of oral tissue growth, development, aging, maintenance, and repair, taking into consideration the dynamics of the oral environment as well as chemical, genetic, immunological, microbiological, hormonal, neural, nutritional, and behavioral variables that affect oral structures and functions.

Economic Cost of Dental Disease

Dental diseases are a major public problem, and the cost of treatment consumes 6.5% of total health expenditures. An estimated 133 million Americans go to the dentist every year and in 1987 spent $32.8 billion. To this figure must be added the days lost from work and lost productivity caused by pain and discomfort.

Forty Years of Progress

The Congress created the National Institute of Dental Research (NIDR) in 1948 because it was appalled at the impact of dental diseases on military inductees--ineligibility due to lack of teeth and the extraordinary cost of treating those accepted--and on the American population in general. Considerable progress has been made over the past 40 years toward understanding and solving the myriad dental disorders.

Mr. Chairman, I wish to devote my testimony today to a review of the substantial progress that has been made over the life of the NIDR, and to demonstrate that the investment of public funds in this field of research has yielded a high dividend to the taxpayer estimated at $2 billion per year.

Caries

In the early 1960's, the Institute identified the major components of the caries (tooth decay) process, which consisted of a combination of a cariogenic diet, susceptible tooth surfaces, and the bacterium Streptococcus mutans. With the rapid accumulation of data supporting this theory about the disease process, the Institute then established a National Caries Program. Since the 1970's, there has been a substantial drop in the prevalence of cavities in the United States. In the single decade 1971 to 1980, the average number of decayed, missing, or filled teeth for children aged 5 to 17 dropped almost 35% from 7.25 to 4.77. In 1988, the Institute updated its earlier survey of children and reported that nearly 50% of children have never had a cavity, while the remaining children have fewer and smaller cavities than children surveyed in 1980.

Periodontal Diseases

The need to probe the origins of periodontal disease lay behind the NIDR's expansion of microbiological and immunological investigations. Studies in the 1950's disclosed the infectious nature of this group of diseases, but their etiology and mechanisms of progression remained obscure. The decade of the '60's produced research that confirmed a bacterial role in periodontal disease and demonstrated that immunologic reactions to these bacteria in affected gum tissues had an important part in the disease process.

Studies carried out in the 1970's underscored the common denominators among "dental" and "medical" conditions. Biomedical specialists were intrigued to find, in easily-accessible oral tissue, models of infectious and other disease processes occurring elsewhere in the body. Periodontal diseases, for example, have many of the features of certain chronic and debilitating disorders such as diabetes and arthritis.

Recent research findings indicate that some oral bacteria are able to adhere to proteins deposited on teeth by saliva. Some bacteria have surface "adhesins" that interact with receptors on other bacteria or on oral tissues. Still another possibility is that certain bacteria are attracted by chemicals produced by bacteria already present in a diseased periodontal pocket. The study of these salivary proteins, surface adhesins, and chemical attractants at the molecular level is leading to novel approaches to controlling periodontal disease. For example, it may be possible to synthesize one or more varieties of adhesin molecules and insert them into a periodontal pocket. The adhesins would interact with receptors on bacteria already there and effectively block further colonization by destructive bacteria.

The overall goal of this extensive research is the ultimate prevention of periodontal disease.

AIDS

With the advent of the AIDS epidemic, dental scientists applied their skills to this problem and have identified early oral changes associated with AIDS. They are documenting the history of oral signs and symptoms that occur as the disease develops. Indeed, oral symptoms can be one of the earliest indication of the presence of the disease. It has been established that certain protective white cells are not destroyed by the human immunodeficiency virus, but may, in fact, be the vehicle by which the virus is spread throughout the body. As part of this research, dental scientists have discovered a component in saliva that inhibits the infectivity of HIV. This is another example of a growing number of salivary components that aid in the protection, maintenance, and repair of oral tissues. This is an important piece of information for understanding the routes of infection and prescribing preventive behavior.

The Future

Although we have covered much ground and have expanded the knowledge base, much work still needs to be done:

- The need to focus on individuals of any age who are highly susceptible to oral diseases.
- The need to develop new diagnostic methods for early identification of those individuals susceptible to caries and periodontal diseases.
- The need for new approaches to prevent, repair, and even reverse disease processes.
- The need for new diagnostic methods to facilitate early, more accurate detection of oral lesions.
- The need to understand what happens to the oral tissues in relation to changes in immunity, in endocrine gland function, and in other body systems; and how oral health affects and is affected by systemic diseases common in old age.
- The development of intra-oral controlled-release devices for treating individuals at high risk for oral health problems.

In order for us to achieve the full potential of the research supported to date, a need exists to initiate clinical research centers which would provide a step toward the transfer of dental technology from the laboratory to the practicing dentists and the public. Such a multidisciplinary and concentrated approach will accelerate the application of dental research findings toward the prevention and cure of dental diseases. As such, we are requesting $2 million to initiate three new clinical research centers.

Budgetary Needs

We respectfully request a funding level for the National Institute of Dental Research of $171 million for the fiscal year 1990. This level will allow for a balanced research program in dental science, by supporting regular research grants, research centers, training, and intramural research.

It should be noted, Mr. Chairman, that the association supports the NIH funding level of $8.416 billion recommended by the Ad Hoc Group for Medical Research Funding.

Mr. Chairman, this concludes my testimony as it relates to the National Institute of Dental Research. At this time, I would like to take the opportunity to address additional program areas which provide important support for the research conducted and supported by NIDR.

Specifically, I would like to call your attention to the Biomedical Research Support Grant (BRSG) program, which is being eliminated in the President's budget. This program is designed to meet emerging opportunities in research, to pursue new ideas, and to develop young scientific talent. The BRSG has become an important part of the dental research effort in this country. We believe that the proposed elimination will weaken institutional research in the health sciences. Therefore, we urge the committee to restore this program and increase funding to the 1989 level.

We also urge funding of the NCHSR at $30 million.

Senator **Hatfield**. Thank you, Dr. Squier. I want to commend the Institute and the profession you are representing this morning. I am very pleased to note the tremendous progress that has been made in your surveys on cavities and such.

Having been reared in an area of my State that had no minerals in the water, I have become a case study in dentistry of any kind. If you want an example, I have it in my mouth.

Mr. **Squier**. Great support for fluoride.

Senator **Hatfield**. I am so happy that my four children grew up in another generation where we had preventive fluoridation and other such matters that give them a much better mouth than I have.

Mr. **Squier**. We are proud of it too.

Senator **Hatfield**. Thank you.

Mr. **Squier**. Thank you.

STATEMENT OF DR. HARRIET PRESSER, POPULATION ASSOCIATION OF AMERICA

Senator **Hatfield**. Dr. Harriet Presser representing the Population Association of America.

Dr. **Presser**. Mr. Chairman, my name is Harriet Presser. I am professor of sociology at the University of Maryland and president of the Population Association of America [PAA]. I appreciate the opportunity to speak to you today on behalf of this association.

The Population Association of America represents about 2,700 demographers, economists, geographers, sociologists, and other social scientists. Although PAA members receive support from many sources for their research, the major funding source is the National Institutes of Health, particularly the Center of Population Research at NICHD and the National Institute on Aging.

Demographic research supported by NIH focuses on critical issues of health policy such as adolescent pregnancy, AIDS research, the care of children, the oldest old, and health and longevity.

The Demographic and Behavioral Science Branch within NICHD Center on Population Research supports a wide range of research projects as well as research centers that specialize in demography and the behavioral sciences.

For the past two decades, the Branch has taken the lead in funding studies to document the causes and consequences of adolescent pregnancy and childbearing. The basic research on this topic is now over 10 years old, and the Branch plans to support research that will update our understanding of adolescent fertility, which remains a very important concern.

A major research effort is underway to improve our knowledge about sexual behavior. This knowledge should help develop effective AIDS prevention strategies.

There are dramatic changes in the work and family lives of American parents now that one-half of all mothers with young children are in the labor force. This affects the way we care for children. Indeed, over one-half of all children—one-half of all parents—one-half of all mothers with children under age 1 are now in the labor force, and there are clearly problems of infant care that merit our attention.

Initiatives such as these will be jeopardized without additional funding for NICHD. Last year Congress increased the appropriations for NICHD, but all of the money was earmarked for new projects. Therefore, the Institute had to make reductions in the number of competing grants it awarded and also was forced to reduce funding to its centers by 17 percent.

For the fiscal year 1990, the administration has requested $444 million for NICHD. The Population Association of America urges this committee to continue its commitment to quality research at NICHD by supporting an appropriation level of $584.6 million. This amount would put NICHD's award rate at 30 percent.

Another important source of funding for demographic research is the National Institute on Aging. Demographic research efforts have helped to shift the policy and planning debate away from chronological age to the examination of other factors related to the aging process.

One major initiative currently underway at NIA is research on the relationship of health to longevity. What does increased longevity mean for active life expectancy in terms of disability and long-term care, community and social services, and economic and employment needs?

Another research effort at NIA focuses on the oldest old which is 85 years and over. Although this is the fastest growing segment of our population, little is known about this group. Further research is critical if we are to forecast life expectancy and disability expenses and develop appropriate plans for long-term care.

A proposed research initiative is a new survey on work and retirement decisions. Such decisions play an integral role in determining the health of individuals in later life and have direct relevance for public policy decisions on Social Security, Medicare, and Medicaid.

Last year Congress responded to the tremendous demand for research at NIA by increasing appropriations from $178 million to $195 million. We urge this subcommittee to continue this funding trend in anticipation of the aging of the baby boom.

PREPARED STATEMENT

We recommend an additional increase for fiscal year 1990 to $281 million. This level would allow NIA to fully fund 17 percent of approved grants and enable the National Institute on Aging to continue a broad spectrum of research.

I thank you very much for this opportunity to speak before you.

[The statement follows:]

STATEMENT OF DR. HARRIET PRESSER

Mr. Chairman and Members of the Subcommittee on Labor, Health and Human Services and Education of the House Appropriations Committee, my name is Harriet Presser. I am a Professor of Sociology at the University of Maryland and President of the Population Association of America (PAA). I appreciate the opportunity to speak to you today regarding the appropriations for the National Institute of Child Health Development (NICHD) and the National Institute on Aging (NIA) at the National Institutes of Health (NIH). Your interest and support for the National Institutes of Health in times of budget constraints have enabled this institution to maintain its preeminence in the scientific research arena.

I appear before you today on behalf of the Population Association of America (PAA), the professional research society of some 2,700 demographers, economists, geographers and sociologists. As successfully elected representatives, I am sure that all of you have used demographic analysis of your district and constituency, and that you know how powerful these tools can be. The demographic research supported by NIH is focuses on critical issues of health policy, such as adolescent pregnancy, AIDS research and the so-called "oldest old." While PAA members receive support from many sources, an important funding source for demographic research comes from NIH, particularly through the Center for Population Research at NICHD and The National Institute on Aging.

The Demographic and Behavioral Science Branch within NICHD's Center for Population Research supports a wide range of "big picture" research that can relate the behavior of individuals to society, including: family and household structure; factors affecting fertility; child care, female employment and fertility; adolescent pregnancy and childbearing; population movements; and, factors affecting mortality. Additionally, NICHD supports centers in the demographic and behavioral sciences at major U.S. research institutions.

One of this Branch's main initiatives for the past 10 years the Branch has been the funding of over 70 studies documenting the causes and consequences of adolescent pregancy and childbearing. More recent research has documented the increase in sexual activity during the 1970s and factors associated with early initiation of sexual activity and trends. Since the early research on of teen childbearing is a decade old, the Branch hopes to fund analyses of the consequences of early childbearing in the 1980s. This project will update what is known about the socio-economic and health consequences of adolescent pregnancy and childbearing for young mothers, fathers, and other family members, using existing data.

In addition to adolescent childbearing issues, the potential impact of fertility trends on the size and characteristics of our population continues to be a vital part of the research program. Fertility trends are influenced by many changes in our society, delay in marriage, the continuing high divorce rate, increased participation of women in the labor force, and the difficulty in arranging for satisfactory child care.

A major research effort is also underway to fill in the gaps in our knowledge concerning sexual behavior. This major research effort demonstrates how Institute's research capability can be directed promptly to new public health crisis and complement the on-going biomedical research program at the Institute.

It is unlikely that a fully effective treatment or vaccine for AIDS will available in the near future. The consensus therefore, is that efforts to halt the spread of the human immunodeficiency virus (HIV) will rely on preventive efforts, requiring an understanding of sexual behavior-- an area in which there is a relative scarcity of reliable data.

Alfred Kinsey's pioneering research program conducted over 40 years ago remains one of the few surveys of sexual behavior.

While the surveys are now outdated, as well as having other limitations, they continue to be used because of a lack of alternative data.

With the emergence of the AIDS epidemic, the need for new data has become critical, and the Demographic and Behavioral Science Branch (DBSB) at NICHD became the logical unit to coordinate this groundbreaking research. The Branch has been able to respond quickly because of its relationship to researchers who are skilled at designing surveys with sensitive questions. These and many other initiatives will be jeopardized without additional funding for the Institute.

Congress increased the appropriations for NICHD in FY 1989. However, all of the additional money was earmarked for new projects. Therefore, The Institute had to make reductions in the number of competing grants it awarded and was forced to reduce funding to its Centers by 17 percent.

For FY 1990 the President has requested $444 million for NICHD. The Population Association of America urges this Subcommittee to continue its commitment to quality research at NICHD and support an appropriations level of $584.6 million. This amount would put NICHD's award rate at the 30 percent level--the higher end of the award rates at NIH--and would enable the Institute to continue to fund high quality research related to maternal and child health.

Another important source of demographic research comes from the National Institute on Aging (NIA). Only a decade ago the role of demographers in aging was largely descriptive, simply documenting the dramatic increase in the number of elderly. As demographic techniques have become more analytical in fashion. it has produced new insights into the links between mortality improvements and changes in disability and morbidity linkages, and more reliable projections of service demands. New research efforts have also helped to shift the policy and planning debate away from chronological age, to the examination of other factors related to the aging process.

One major initiative currently underway at the National Institutes on Aging is research on the relationship of health to longevity. What does increased longevity mean for active life expectancy in terms of disability and long-term care, community and social services and economic and employment needs? Another research effort at the National Institute of Aging focuses on the "oldest old," age 85 or more. While this is the fastest growing segment of our population, little is known about the group in terms, of the health expenses of people in this age group as they grow older. Such information is critical if we are to forecast life expectancy and disability expenses and develop appropriate plans for long-term care.

A proposed research initiative is a new survey on work and retirement decisions, which play an integral role in determining the health of individuals in late life and have direct relevance for public policy decisions on Social Security, Medicare and Medicaid.

Last year Congress responded to the tremendous demand for research at the National Institute on Aging by increasing the appropriations from $178 million to $195 million. We urge this Subcommittee to recommend an additional increase for Fiscal Year 1990 to $281 million. This level would allow NIA to fund fully 37 percent of approved projects and enable the National Institute on Aging to continue a broad spectrum of research including: funding for the "oldest-old" initiative; planning and developing appropriate plans for long term care; a new survey on retirement and health issues; and a longitudinal study on aging.

In summary, Mr. Chairman, we believe that the amount of $584.6 million for NICHD and $281 million for NIA are amply justified, and we respectfully urge you to consider increased funding for NICHD and NIA in the appropriation process.

Senator **Hatfield**. Thank you. Dr. Presser, I would be very happy to put you in contact with a doctoral student at the University of Pennsylvania who is doing a study on 13-year-olds, in what would be called a blue collar neighborhood, who are seeking to become pregnant for the status that it gives them to have a child, as in the case of their mothers having become pregnant at 13 or 14.

This is a very interesting study that is nearing completion now, as the doctoral program is nearing an end as well. I would be very happy to give you the name and address if you would like to contact that person.

Ms. **Presser**. Fine. We know overall that although adolescent fertility rates are going down, that the age at which young children—actually——

Senator **Hatfield**. There are so many misconceptions that somehow those are accidental pregnancies. Whereas, in this particular group of persons being surveyed, it is intentional. It is an effort that is being made to become pregnant. So, it is not a matter of prevention there so much, from the standpoint of information, knowledge, and contraception, but rather from the standpoint of a cultural pattern that is developing.

Ms. **Presser**. I spoke here about 15 years ago on a panel on teenage pregnancy. It is rather sad to know that we have not moved that far.

Senator **Hatfield**. Thank you very much.

STATEMENT OF MARGARET M. WILLIAMS, CHAIRMAN, NATIONAL SUDDEN INFANT DEATH SYNDROME FOUNDATION

ACCOMPANIED BY DALE P. DIRKS, LEGISLATIVE CONSULTANT

Senator **Hatfield**. I would like to invite Margaret M. Williams, the chairman of the National Sudden Infant Death Syndrome Foundation.

Good morning.

Ms. **Williams**. Good morning, Senator. My name is Margaret Williams and I am chairman of the National Sudden Infant Death Syndrome Foundation [SIDS]. I am also a grandmother who lost a child to SIDS. So, I speak from a very personal point of view.

Today I would like to discuss sudden infant death——

Senator **Hatfield**. Would you introduce your associate, please, for the record.

Ms. **Williams**. Oh, I am sorry.

Mr. **Dirks**. I am Dale Dirks, legislative consultant for the SIDS Foundation.

Senator **Hatfield**. Thank you. We are happy to have you here too.

Ms. **Williams**. I would like to discuss the tragedy of sudden infant death syndrome, or SIDS, or crib death, as it is often called.

It is the No. 1 cause of death in infants and children in our country. Instances of SIDS have been recorded in Biblical times but it has only been recently that we have really identified SIDS as a specific entity.

The typical case is taking a seemingly healthy, happy baby and putting him to bed, or her to bed, and going in later and finding the child dead without any indication prior to this that there is anything wrong with this child.

Sudden infant death syndrome crosses all barriers of life. Every ethnic, social, economic, racial group is affected by SIDS. Very little is known about the causes of SIDS or there are no effective ways for detecting or preventing SIDS.

I know because, as I told you, this crossed into our family, and it does every year into 7,000 families in this country.

The National Institute on Child Health and Human Development at the National Institutes of Health is the primary Federal agency that provides resources for sudden infant death syndrome research. The NICHD SIDS program began in 1963 and has maintained a modest resource base for SIDS and SIDS-related research.

In last year's report accompanying the Senate LHHS appropriations measure, the committee asked the National Institute on Child Health and Human Development to prepare a report and a plan for a 5-year study and emphasis on SIDS. They convened a panel and a group of outstanding people who have worked in SIDS research to develop this plan.

What they did discuss and what we really already know is that we are far, far behind where we should be. Our commitment is not what it should be. We do not know what causes SIDS. We cannot prevent it. In fact, this is one of the main factors in that we are No. 18 in mortality of our children in the world, which is really a disgrace for this country.

There is a common theme that runs through the discussion of all SIDS research, and it is that there is some abnormality in the development that makes these children vulnerable to internal and external causes that trigger death. To prevent SIDS, we must develop an understanding of the way in which these triggers affect these children and why they are vulnerable. We have to understand this and try to determine the markers that will help us to identify these children and then eventually eliminate this tragedy.

There is a 5-year plan and it enumerates the research agenda to expand the knowledge of this vulnerability and to identify the triggers. We have the capability and the technology, if we would only use this to conduct this 5-year plan.

I would like to sit here in 1994 when the International Conference on SIDS will be in Washington and say we have finally found the reason and have eliminated this terrible scourge.

PREPARED STATEMENT

The 5-year research plan must be funded. In the President's 1990 budget there is only $3 million. In order to meet the plan that your committee has requested, we need an additional $8 million in this year's budget. This would complement the $3 million and hopefully get this program off the ground.

Too many babies continue to die. We need to do something about this, and I hope you will consider this among the many requests.

Thank you.

[The statement follows:]

STATEMENT OF MARGARET M. WILLIAMS

Mr. Chairman and members of the Subcommittee I am very pleased to appear before you today to discuss the tragedy of Sudden Infant Death Syndrome, and the federal response to a disorder that is the number one cause of death in infants after the first week of life, and accounts for the death of about 7,000 babies per year. Instances of SIDS have been recorded since biblical times, but it is only in more recent years that it has been recognized as a specific entity. In the typical case an apparently healthy infant, usually between the ages of three weeks and seven months, is put to bed without the slightest suspicion that anything is out of the ordinary. Some time later the infant is found dead.

Mr. Chairman, Sudden Infant Death Syndrome is a horrible disorder that knows no economic boundaries and affects babies and families from every walk of life. Very little is known about the causes of SIDS or effective methods of preventing this indiscriminate scourge.

The National Institute on Child Health and Human Development at the National Institutes of Health is the primary federal agency that provides resources for Sudden Infant Death Syndrome research. The NICHD SIDS program began in 1963 and has maintained a modest resource base for SIDS and SIDS related research.

In last year's report accompanying the Senate LHHS Appropriations measure, Mr. Chairman, the Committee asked the National Institute on Child Health and Human Development to prepare a report detailing a 5-year Sudden Infant Death Syndrome Research plan. In response to the Committee's request, the NICHD convened an esteemed group from a number of key fields to discuss the current state of knowledge and articulate research needs. As the report indicates, we are far, far behind in our national commitment to studying and preventing SIDS cases in the U.S. In fact, SIDS is one of the factors that places the U.S. 18th in the world in infant mortality rate which is truly unthinkable.

Mr. Chairman, a common theme runs throughout the discussion of all SIDS research areas. It is that some abnormality in development makes some infants vulnerable to internal or external factors which trigger death. To prevent SIDS, we must develop an understanding of the way in which these infants are vulnerable, discover their markers and determine the interaction of the vulnerability with stresses.

The 5-year plan enumerates a research agenda to expand knowledge on vulnerabilities of infant development and the series of events (including triggers) leading to sudden infant death. The research capability and technology are available and ready to conduct the studies in the 5-year plan to hasten progress in reaching the goal of eliminating SIDS.

Mr. Chairman, the SIDS 5-year Research plan must be funded! The President's fiscal year 1990 budget does not contain sufficient resources to implement the fiscal year 1990 portion of the plan. In fact, the cost of implementing the 5-year plan would be an additional $8 million in FY'90 specifically designated for this plan. This would complement the current $3 million that is within the President's budget request. Mr. Chairman, now is the time, even during this time of fiscal constraint, to implement this new comprehensive plan. Too many babies are dying, and we need to know why, and we need to be able to do something about it.

Thank you for the opportunity to present our views.

Senator **Hatfield**. Thank you, Ms. Williams. As you know, when Senator Hollings and I directed the 5-year plan in SIDS we, of course, anticipated and hoped that we would be able to fund it fully before the fifth of the 5-year plan that we helped establish.

We are, as you know, moving upward, but very slowly, from $1.8 million in 1988 to the $3.2 million figure for 1990. I can appreciate your concern about that.

Also, as you know, we have one of the two National Institute's programs in Portland. I believe the other program that is doing research in this field is in Atlanta. So, I have a very special interest not only to the program in general, but to the program in the specific.

We will do our very best to try to respond to the needs of that program, along with the others.

Unfortunately I suppose in some ways this is one of those—it is really a good fortune and bad fortune situation. Bad fortune from the standpoint of the lack of constituency to advocate and support, and good fortune in that there is not a larger constituency. This is one of those things where we would like to abolish all the constituencies by being able to find the answers.

But there are so many of these, sometimes referred to as "orphan diseases" that do not have public understanding, broad public understanding. I do not believe that we should redistribute in the sense of taking from one to give to the other. But, rather, we should increase our commitment—base commitment to all.

I want you to know there are people who are committed to these orphan disease programs, yet at the same time we are competing for moneys that we also recognize are important on the epidemic broad-based programs. As you know, we started out with $300 million in AIDS and we jumped it to $600 million. Then to $900 million. This year we are $1.1 billion just for that one particular disease.

I do not regret $1 of that. But the point is that then we go through contortions to find an $8 million increase in a program like SIDS.

I want you to know your frustrations are also shared by many of us on the committee.

Ms. **Williams**. I would just like to say one more thing. I am not sure it is an orphan disease and I am not sure there is not a constituency. Some 7,000 families a year are affected, and if you just multiply that by a factor of 10 people—7,000 babies—and in 10 years. When Shawn died, I had over 200 letters from people that I thought I knew well who said to me they had either had a SIDS tragedy in their direct family or a neighbor or a friend.

I think it is one of these closet diseases. We do not want to talk about babies that die, especially when we do not know how to find them or how to stop it.

Senator **Hatfield**. Perhaps I mislabeled it as an orphan disease. But it is at least being treated as one——

Ms. **Williams**. Yes; but I would like to help take it out of the closet——

Senator **Hatfield** [continuing]. In terms of the budgeting process.

Ms. **Williams**. Yes.

Senator **Hatfield**. Mr. Dirks, you are certainly no stranger to this process. We remember with great pleasure your father and his many years of contribution here on Capitol Hill.

If there are words that you wish to offer today, certainly we would be pleased to hear from you too.

Mr. **Dirks**. I appreciate the opportunity to appear with Mrs. Williams and I have nothing to add, Senator.

Senator **Hatfield**. You carry the imprint of your father. Thank you very much.

Ms. **Williams**. I would like to present you with a copy of the plan.

STATEMENT OF LAWRENCE MELI, PRESIDENT, DEAFNESS RESEARCH FOUNDATION

Senator **Hatfield**. Now, Mr. Larry Meli, president of the Deafness Research Foundation [DRF].

Mr. **Meli**. Good morning.

Senator **Hatfield**. Good morning.

Ms. **Williams**. Mr. Chairman, I am Lawrence Meli, a television producer, president and on the board of directors of the Deafness Research Foundation, a foundation board member of the Alexander Graham Bell Association for the Deaf, chairman-elect of the Council of Organizational Representatives, but most important, the parent of two boys. One, our oldest son, John Robert, 7, has a profound hearing loss.

I would like to begin by thanking you for giving me the opportunity to testify on behalf of the Deafness Research Foundation, a nonprofit, volunteer organization which for more than 30 years has been dedicated to finding the preventions, treatments, and cures for hearing disorders by developing new and unproven researchers who address these areas.

In fact, many of today's established researchers received a DRF grant early in their career or with a new research project. The DRF will do everything possible to continue its goal of funding startup and seed research and to assist the new Institute in developing bona fide researchers with meaningful exploration into the causes and cures of deafness.

When my wife and I discovered our son's hearing loss at 12 months, I spent days in my office calling all over this country to find the best possible treatment, therapy, and rehabilitation. I am a little embarrassed to say that back then I thought a hearing aid would do for John's hearing what eyeglasses do for vision. Perhaps I took for granted the technological and medical advances this country has made and assumed that they were applied in all areas of medicine.

Advances were few and there was plenty of catching up to do. I vowed then to help make a better world for my son, John, and people like him.

My appearance here today, along with my colleagues testifying before you about deafness and other communication disorders, marks a triumphant return to Capitol Hill for those of us who have worked innumerable hours with you, our representatives here in Washington, DC, to see through to fruition the creation of NIH's newest institute, the National Institute on Deafness and Other Communication Disorders.

Thanks to you and your support, my promise to John will be fulfilled. Now that the monumental first step has been taken to create the Institute, its first full year of funding in fiscal year 1990 is no doubt critical to its future success. By creating the NIDCD, you and your colleagues in the Congress have recognized the need for our health research community to pay greater attention to deafness.

Historically whenever a concentrated, well-directed, and fully funded effort is made toward curing a disease, breakthroughs are fast and furious.

For example, the Task Force for the Development of a National Strategy for Deafness and Other Communication Disorders has stated that in the regeneration of neurosensory mechanisms that within the next 10 to 20 years of sustained investigation it is likely that we could see clinical gains from the regeneration of hair cells which, incidentally, help change sound waves into electrical impulses for the brain to process, which could benefit up to 80 percent of hearing-impaired Americans.

I pray for that type of result, but prayers alone will not help my son. Given the NIDCD's fiscal year 1989 budget of $91,677,000, the President's fiscal year 1990 NIDCD budget request of $96,116,000 simply will not serve the needs of those 28 million Americans living with hearing and other communication disorders.

With this in mind, the Deafness Research Foundation is proud to strongly support the very able Acting Director of NIDCD, Dr. Jay Moskowitz, in his fiscal year 1990 professional judgment recommendation of $131,481,000.

Allow me to bring the reality and the importance of significantly increasing funding for the NIDCD into perspective by returning to my role as a concerned parent who for the past 6 years has been active in the world of Americans with hearing impairments. I have learned a lot about the limitations placed upon those with hearing impairment. Simple things like making an appointment or a reservation in a restaurant, to the basic education of a first grader.

I believe that those with normal hearing cannot possibly imagine the devastation one experiences with the inability to clearly understand the spoken word.

Mr. Chairman, of every 22 infants born in the United States, 1 has or shortly will have a hearing problem; 28 million Americans are believed to have some degree of hearing impairment; one-third of all Americans over age 65 will have a significant hearing impairment, a number that will most certainly increase as today's young people continue to expose their hearing to loud music.

PREPARED STATEMENT

With these statistics, it will be difficult to keep deafness an invisible and misunderstood disease, and with your continued support for the National Institute on Deafness and Other Communication Disorders, for the first time deafness cures and preventions will be within our grasp.

Thank you for permitting me to share the Deafness Research Foundation's views with you.

[The statement follows:]

STATEMENT OF LAWRENCE MELI

I am Lawrence Meli, a television producer, President and on the Board of Directors of the Deafness Research Foundation, foundation board member of the Alexander Graham Bell Association for the Deaf, Chairman-elect of the Council of Organizational Representatives, but most importantly, a parent of two boys, one, our older son John Robert, seven years old, has a profound hearing loss.

I would like to begin by thanking you for giving me the opportunity to testify on behalf of the Deafness Research Foundation, a non-profit, volunteer organization, which for more than 30 years, has been dedicated to finding preventions, treatments and cures for hearing disorders by developing unproven researchers who address these areas. Many of today's researchers received a Deafness Research Foundation grant early in their career or with a new project. The Deafness Research Foundation will do everything possible to continue its goal of funding start-up and seed research and to assist the new Institute in developing bona fide researchers with meaningful exploration into the cause and cures of deafness and into helping those with a hearing impairment every opportunity they deserve for a fulfilling life.

My appearance here today, along with my colleagues testifying before you about current and future deafness and other communication disorders research, marks a triumphant return to Capitol Hill for those of us who have worked innumerable hours with you. our representatives here in Washington, D.C., to see through to fruition the creation of NIH's newest Institute, the National Institute on Deafness and Other Communication Disorders (NIDCD). Thanks to you and your support, my promise to John will be fulfilled.

Now that the monumental first step has been taken to create the Institute, its first full year of funding in Fiscal Year 1990 is no doubt critical to its future success. We all understand that the NIDCD was created in large part to remove the funding inequities that resulted from the National Institute of Neurological and Communicative Disorders and Stroke (NINCDS) allocating only approximately 20% of its budget to its Commuicative Disorders Program, which is a disproportionate amount given the millions of Americans affected. By creating the NIDCD, you and your colleagues in the Congress have recognized the need for our health research community to pay greater attention to deafness -- the disease of silence.

Historically, whenever a concentrated, well directed, and fully funded effort is made towards curing a disease, breakthroughs are fast and furious. For example, the Task Force has stated that in the regeneration of neurosensory mechanisms, within 10-20 years of sustained investigation it's likely that we could see clinical gains from the regeneration of hair cells (which help change sound waves into electrical impulses for the brain to process) which could benefit up to 80% of hearing impaired Americans.

I pray for that type of result. But prayers alone will not help my son. Given the NIDCD's Fiscal Year 1989 budget of $91,677,000, which was approved for transfer from the NINCDS, the President's Fiscal Year 1990 NIDCD budget request of $96,116,000 simply will not serve the needs of those 28 million Americans living with hearing and other communication disorders. The President's Fiscal Year 1990 budget request does not even keep pace with the Biomedical Research and Development Price Index which calls for a 5.6% increase in dollars from 1989 to 1990 simply to maintain the funding value from one year to the next. With this in mind, the Deafness Research Foundation, named by the Task Force as one of the NIDCD's reviewing organizations, is proud to support strongly its very able Acting Director, Dr. Jay Moskowitz in his Fiscal Year 1990 professional judgment recommendation of $131,481,000.

For the NIDCD to implement its mandate, Dr. Moskowitz convened the Task Force to assist the NIDCD in preparing a plan to initiate, expand, intensify and coordinate the activities of the Institute regarding disorders of hearing, balance, voice, speech, language, taste and smell. Towards this end, the new law requires the NIDCD to establish a data system, a national information clearing house, and multipurpose research centers.

Further, in its March 1989 Draft Report, the Task Force outlined a comprehensive program of research on deafness and hearing disorders, consisting of both an intramural and extramural program. The existing intramural program of the NIDCD consists of those programs transferred from NINCDS: the Laboratory of Molecular Otology, the Speech and Voice Unit, an audiology service, and an otolaryngology-head and neck surgery service. According to the Task Force, in terms of program diversity, personnel resources and laboratory space, the present intramural resources are inadequate to meet the mandate of the new law. The Task Force believes that the current program must be expanded to include molecular biology, molecular genetics, advance cell physiology, and electrophysiology applied to the auditory system in animal models and in humans. The Task Force also believes that an expanded intramural program could serve as a central gene bank for the emerging research on the genetics of deafness.

On the extramural program side, the NIDCD's Task Force has recommended a number of topics, about which little is currently known, that needs to be studied: acoustic tumors, "autoimmune" ear disease, genetic hearing loss, infectious diseases that cause hearing loss, Meniere's Syndrome, tinnitus, otosclerosis, perilymph fistula, sensorineural hearing loss and sudden deafness.

All of this of course requires manpower, time, energy, dedication and financial resources. The more than thirty organizations, agencies and institutions that worked so diligently to get the NIDCD through its initial stages of development, are just a microcosm of the manpower, time, energy and dedication necessary for the Institute to be a success. It is clear that the financial resources must now come from you and your colleagues on Capitol Hill to make the difference for this Institute to become the leader in finding preventions, treatments and cures for hearing and other communication disorders. Estimates reveal that hearing, speech and language disorders alone cost the U.S. economy $30 billion a year in lost productivity, special education costs and medical costs.

Of every 22 infants born in the United States, one has or shortly will have a hearing problem. As I stated above, 28 million Americans are believed to have some degree of hearing impairment; and one-third of all Americans over age 65 will have a significant hearing impairment.

Allow me to bring the reality of these numbers and the importance of significantly increased funding for the NIDCD into perspective by returning to my role as a concerned parent, who for the last six years has been active in the world of Americans with hearing impairments. I have learned a lot about the limitations placed upon those with a hearing impairment. But I believe those with normal hearing cannot imagine the devastation one experiences with an inability to clearly understand the spoken word.

Like all parents, my wife and I hoped for children who would be happy, healthy, and able to enjoy the full range of life's blessings. The discovery that we had a deaf child brought with it unspeakable feelings of disbelief, anger, frustration, helplessness, even guilt. Like many parents of deaf children, we grieved for the loss of the child we had expected. And eventually we accepted the reality, and the need to learn about and help the child that was ours.

It will cost much more to educate and support John than a child who hears normally. As an adult, he will probably earn far less than a comparably gifted hearing person. Such a waste is something our society, which needs all the gifts and talents it can develop, can ill afford. And despite the billions of dollars it takes to manage these communicative disorders, currently we spend only about three and a half dollars for each person so afflicted toward finding cures and preventions.

More money alone, however, is not the answer. But money appropriated to the NIDCD would target the problems of hearing, speech, and language disorders, with a commitment and a direction that would go a very long way towards getting the answers. This kind of support is critically needed, today.

On behalf of the Deafness Research Foundation, thank you for allowing me to share its views with you.

Senator HATFIELD. Thank you, Mr. Meli. At this point I would like to ask you for clarification for myself. The Alexander Graham Bell Association, is this a citizen's advocate group? I am sorry, I do not know.

Mr. MELI. It is an educational-oriented group that was founded by Alexander Graham Bell teaching oral communication to deaf children.

Senator HATFIELD. Is there a national advocate group that is also raising funds for research in this field?

Mr. MELI. Well, the Deafness Research Foundation certainly raises funds for seed and startup research into causes and cures of deafness, and has been doing so for 30 years.

Senator HATFIELD. Do you have any figures on moneys that are raised by the private associations and private groups? Any general ballpark figures?

Mr. MELI. Well, I would say to you that the Deafness Research Foundation, being the most prominent of those organizations, raises approximately $2 to $2.5 million a year for startup research. In no way can we—we believe because of this not being a life-threatening situation to attract attention to this problem has been certainly an uphill struggle for the past.

Senator HATFIELD. Have they focused in on certain key universities in the allocation of those funds for research?

Mr. MELI. We have a part of the Deafness Research Foundation that is comprised of 2,500 otolaryngologists. It is called the Centurians. That group rotates through our grants approval board process. There are six or nine members on that process that evaluate presentations or applications from all around the country.

I would say to you that our grants go far and wide to all 50 States. They have over the last 30 years.

Senator HATFIELD. When some of us gave the leadership to the establishment of this Institute, and, as you know, I can understand the NIH in general, that the proliferation of institutes oftentimes do not carry with it the commitments to fund those additional institutes, and they have been more or less reluctant to see a proliferation.

Like in the field of cancer and the field of heart disease, and some of those other areas, that there have been significant moneys raised by citizen groups and, therefore, we need careful coordination on the research programs. That they could provide some assistance here for directing or at least coordinating the broadest possible base of research projects.

We have seen an increase here, as you note in your testimony; about a $4 million increase since we established the Institute in 1989. Again, you are kind of preaching to the choir this morning, so to speak.

As a father, I can speak too in terms of hearing deficiencies of two of my four children. You see, I am wearing a little instrument in my ear. As one who grew up living with his grandmother—in many ways in order that I could be her hearing, for her failed hearing. So, I have had a long involvement.

The American Tinnitus Association is located at the Oregon Health Sciences University, Dr. Jack Vernon, who heads that up in the field of research in tinnitus. So, I just want to again indicate to you, as I indicate to my friends in the research field, we have to use Federal dollars to leverage more out of the private sector.

I think oftentimes, speaking in a broad base, the medical community are not very generous in giving. Whether it is the United Fund or to the local hospital drive. I think that is noted throughout the country.

But, at the same time, I think we ought to not in any way spare the effort to get out there, even beyond the medical community, to leverage as much private money as well as increasing the public commitments through this process, the appropriations process.

I appreciate your leadership that you indicate here through these various associations and your interest in other citizens like you.

Mr. **Meli**. Thank you.

Senator **Hatfield**. It is a very helpful work that you are in. Thank you.

Mr. **Meli**. Thank you.

STATEMENT OF DR. ROBERT T. SCANLON, JOINT COUNCIL OF ALLERGY AND IMMUNOLOGY

Senator **Hatfield**. Dr. Robert Scanlon, representing the Joint Council of Allergy and Immunology.

Dr. **Scanlon**. Good morning, Senator.

Senator **Hatfield**. Good morning, Dr. Scanlon.

Dr. **Scanlon**. I am Dr. Robert Scanlon. I am at Georgetown University Center, and I am here as a volunteer and a member of the Joint Council of Allergy and Immunology which represents approximately 4,200 allergists and immunologists throughout the country.

Senator **Hatfield**. Do you know Dr. John O'Halloran?

Dr. **Scanlon**. Oh, yes.

Senator **Hatfield**. And Mark O'Halloran?

Dr. **Scanlon**. Yes.

Senator **Hatfield**. I have been through their mail recently. [Laughter.]

Very fine people in both their teaching and in their practice. As you know, Dr. Mark, the nephew, is now taking more and more a role of teaching in the department——

Dr. **Scanlon**. Yes.

Senator **Hatfield** [continuing]. At the university. I will give them your regards.

Dr. **Scanlon**. Good. Thank you.

Senator **Hatfield**. Thank you, Doctor.

Dr. **Scanlon**. We are appreciative in being here in helping to increase biomedical research funds for the National Institutes of Allergy and Infectious Disease.

As you know, Senator, the principal aim, or, one of the principal aims for the Institute is to foster good research and to foster good training in teaching and putting out good research scientists. This we are very happy to support.

I would like to add here that knowing the importance of AIDS and AIDS research we would like to ask you all to separate non-AIDS conditions in your funding. Now, this would include bronchial asthma and allergy and immune deficiencies, infectious disease, rheumatoid conditions. All conditions that are important in themselves.

Now, considering just asthma and allergy, it is important to emphasize that 20 percent of the population in America have one of these conditions. This translates into about 34 million Americans who are allergic, and there are 10 million Americans who have bronchial asthma, and 3 million of these are below the age of 18.

Now, when you project this to illness, asthma and allergy is the No. 1 cause of children missing school. As far as adults are concerned, there are 10 million lost working days because of these two conditions.

I do not have to mention the debilitation and the death in conditions from infectious disease and immune deficiency and in rheumatoid conditions. So, these non-AIDS conditions are all extremely important.

I would like to concentrate or recommend increased appropriations in three areas.

One is in research training positions. The President's budget requests that they be decreased by 111. But, as we know, research training is the lifeline of our medical advancement. We have plenty of young scientists who are eager and willing to put in their time in obtaining one of these positions.

As you were mentioning before with private funding, this has decreased significantly. So, a lot of the load falls upon the Institute.

Second are research projects which are extremely—there are many meritorious projects. This is our mechanism in funding these and getting medical advancements. But when we consider that one out of five of these projects is selected, and of those that are funded, only 16 to 18 percent—I mean, excuse me, 16 to 18 percent have decrease in funding, we would like to recommend, if possible, that the number of research projects be increased by 559.

Finally, our research centers which are going to train many young scientists and physicians for treating a lot of the non-AIDS conditions that I told you, these are important areas, and important areas that we have to solve.

So, in closing, Senator, I would like to state, as we all know, that there has been a veritable explosion in medical knowledge and advancement in the past 20 years. This has been translated into better health for the American people. My own feeling is that this has resulted from training of these research scientists as well as the American people and the foresight of Congress in seeing the importance of this funding.

PREPARED STATEMENT

Now, as time has marched on, so have we obtained many medical advances. But as time marches on, we have many medical challenges. So, we have to continue to advance. That is why we are here hoping that we can obtain an increase in funding.

Thank you.

[The statement follows:]

STATEMENT OF ROBERT T. SCANLON

It is a privilege to have this opportunity to testify before you on the issue of funding of biomedical research in the United States. I am Dr. Robert Scanlon and I am here representing the Joint Council of Allergy and Immunology (JCAI). JCAI represents over 4200 allergists and immunologists across the country. This includes physician specialist who belong to the American Academy of Allergy and Immunology and the American College of Allergy and Immunology.

A focus for funding allergy, asthma, and immunology research is located in the National Institute of Allergy and Infectious Diseases (NIAID) under the very effective leadership of Dr. Tony Fauci. Historically, the mission of this Institute is to support medical research and training in order to provide the knowledge and ability to alleviate diseases resulting from disorders of the immune system. In recent years, as you well know, NIAID has assumed a major role in Federal research efforts in AIDS and now at the expense of other diseases. The purpose of my testimony before you today is to address the funding needs of the Institute as they relate to non-AIDS research initiatives.

We are all familiar with asthma and the panoply of allergies many of us suffer from. But it is astonishing to realize that 9.7 million Americans suffer from asthma and approximately 34 million Americans suffer from some form of allergy. Ten million work days each year are lost from asthma and allergies which results in an $800 million loss of wages. Given these startling figures, visualize the productivity we lose as a nation due to asthma and allergy. Furthermore, it is horrifying that the annual death rate from asthma has doubled and that hospitalizations for asthma occur twice as frequently in blacks than in whites.

Despite these statistics, the President's 1990 Budget only supports a 2.6% increase in the NIAID budget for non-AIDs initiatives. Let me highlight the impact that this budget will have on NIAID non-AIDS initiatives:

* Research training positions will be cut, a decrease of 111 positions from even the FY88 budget.

* Under the President's FY90 Budget, 62 research project grants will be cut from the FY89 level.

* Research centers will increase to 16 from the FY89 level but with cuts of up to 1.2% for the existing 15 centers.

We ask the Congress to support an NIAID budget of $6.3 million for all non-AIDS activities. In addition, JCAI believes it is critical that you support the Ad Hoc Group for Medical Research Funding's recommendation of a $8.4 billion allocation for the NIH, a $900 million increase over the FY90

President's Budget Request. Furthermore, we believe funding at this level will provide funds for NIAID to meet its future needs.

Specifically, JCAI recommends the following for non-AIDS activities within the FY90 NIAID budget:

* Research trainee positions be increased to 565, 131 positions above the FY90 President's Budget Request.

* Research project grants be funded at a 50% award rate at 2202 grants, 569 over the FY90 President's Budget Request. This compares with only 1 out of 5 approved grants being funded under the President's request -- the lowest level in history!

* Research centers be funded at $20.4 million for 29 centers or an increase of 14 over the President's Request.

JCAI requests that the Congress seriously consider these recommendations as there are many meritorious research projects and talented research trainees which are not being funded. Our failure to provide adequate support for medical research is threatening to jeopardize the foundation of our research enterprise. The United States, formerly the leader in investment in research and development, has fallen behind West Germany and Japan. In fact, the U.S. spends only about 0.3% of the GNP on medical research and development while approximately 13% is spent on health care. We firmly believe that research is not only a good investment for people but also a sound dollar savings investment. It is vital that we reaffirm medical research and development as a national priority so that the health of this and future generations is not compromised. I would like to take the remaining moments of my testimony to highlight three important areas: research training, research project grants and research centers.

Research Training: Research training is imperative for the continued advancement of medical research. The average length of research training is 8 to 10 years of post-graduate education. Cures and treatments for many diseases and conditions such as asthma, hay fever, eczema, hives and related allergic diseases as well as genetic and acquired immunological disorders are examples of areas of research which need continued development to alleviate the disability associated them.

There is a growing body of information which clearly demonstrates the fact that students are no longer choosing careers in science. Soon it will be too late to get our young students involved in research -- we just cannot continue to start, stop, and start again on making training grants available. Simply put, training is the future hope of medical research in this nation as well as the key to our future ability to eradicate disease, disability and suffering. It is our best investment!

Yet, an NIH decision to increase research trainee stipends in 1989 resulted in a drastic reduction of 1000 trainees NIH-wide; NIAID alone experienced a cut of 111 positions. This cut in trainees has had a significant impact on the many subspecialties including allergy and immunology. Since alternative sources for subspecialty training are declining, we are more dependent on NIH and specifically NIAID support to sustain our effort. The role of immunology in medicine in general is increasing and it is our specialty that supplies the experts in clinical immunology as well as asthma and allergic diseases and the need is increasing at a time that funding is precarious.

We recommend that the Institute be provided adequate funding to ensure 565 non-AIDS trainees in 1990 or $16.6 million. If such a level is not adopted, the supply of skilled practitioners in the fields of allergy and immunology will be seriously compromised.

Research Project Grants: Research project grants are the mechanism by which funds can be distributed nationwide to talented researchers on the basis of the merit of their grant. It is astonishing that less than 1 in 5 meritorious grants are funded at the NIH because of lack of resources. Accompanying this general direction to fund fewer research project grants is the continuing downward trend in the funding of these grants. Grant awards are being cut up to 16-18%. Such a cut in individual grant awards impedes research progress and can adversely affect needed progress in areas such as successful organ transplantation, or for successful diagnosis, prevention, and treatment of occupational allergic diseases.

Increased funds for basic research grants will enable support for:

Fundamental studies of the "late phase" of allergic reactions to understand the basis of this inflammatory response which is so critical to the development of diseases such as asthma and allergic sinus and ear disease.

Lyme Disease which has reached epidemic proportions in the Northeast and mid-West. Additional research is needed to determine the immunologic response to the infectious agent and what new approaches to antibiotic therapy or vaccines might be appropriate.

Analysis of the effects of exposure to environmental agents as a result of our increasingly polluted world. Drugs, chemicals, bacteria, and fungi have a substantial impact on the ability of the lungs to maintain their function and we need to vigorously evaluate the nature and extent of damage these agents may have on the respiratory system.

Research Centers: Research centers at NIAID support research in asthma, immunology, and allergic diseases. Under the President's FY90 Budget, only one additional center will be funded. This is happening at a time when hospitalizations and deaths from asthma are on the rise. Between 1979 and 1986, the death rate from asthma doubled. More resources should be funneled into centers where clinical trials can be performed with the combined expertise of pulmonary medicine and allergy and immunology to address this problem.

The research community applauds your initiatives in the recent years in your support of the medical research budget. This Committee has literally been our savior. Such consideration has allowed the United States to be leaders and bring to realization many spectacular advances in medical treatment and prevention. However, asthma and allergies remain among the most common and expected health problems with 1 in 9 Americans suffering from one of these conditions. Hayfever is the most frequently reported condition for individuals under 18 years only. The decline in funding of all areas of research will undoubtably seriously hamper our achievements and limit our ability to bring discoveries to fruition -- to provide new therapeutic and preventive measures to medicine.

We know you have serious budget concerns and want to present you with our needs. We are totally supportive of your efforts and admire the work you have been able to do as our leaders. We stand ready to assist in any way we can to help medical research be the national priority it so urgently deserves.

This concludes my formal testimony. It has been my pleasure to have the opportunity to testify before you today. I would be happy to answer any questions that you may have for me. Thank you.

Senator HATFIELD. Thank you, Dr. Scanlon. First of all, though, in your comment relating to the separation of the AIDS and the non-AIDS part of the budget, we have an accounting system that does extrapolate and/or separate.

Dr. SCANLON. Oh, good.

Senator HATFIELD. As you may know, we have, for instance in fiscal year 1990, as an example, we have the AIDS program, $400,116,000 in this Institute as against non-AIDS programs of $442,693,000, for a total of $842 million. The same was in fiscal year 1989, which makes for the overall increase for fiscal year 1990, $100,435,000, or $88.8 million for the AIDS part and $11.5 million increase for the non-AIDS programs.

You are speaking as to the matter of researchers. I wish we could have a hearing just on that one subject because I am deeply concerned about the future of that particular need as it relates to the basic demographics from which we are drawing those people at this time. Overwhelmingly a white male 21-year-old population which is projected to be a fairly level part of our demographics in the next 30 years, which obviously means we have to do more to derive that need out of other parts of the population. Hispanics, blacks, women, all of the groups that are not white male 21-year-olds.

I think that is going to have to be a targeted kind of strategy. I do not think it could just be a matter of whether we appropriate *x* number of dollars. When you look at the top of the picture here, too, it seems to me that when you are looking for the lead scientists/researchers for NIH at the public salary levels that we are paying, you will find that that is getting to be a more difficult position to fill as against the young researcher who may come out of a Sarnoff Fellowship or some other where he has been exposed to that potential career in research and has been given some incentive or counseling or whatever, and has excited his interest.

But then you go back beyond that level into the preparation period of elementary and secondary, and it is a miserable record. I mean, we really have eroded. That is a rotting foundation, so to speak, in terms of what we are doing to develop the teachers, the interest of students to come into the math sciences.

I am appalled when I find that out of the 25,000 high schools in this country we have abandoned physics in 9,000 of them because they just cannot pursue the course study without qualified teachers. Then, in about 5,000 in the field of chemistry. We have abandoned 3,000 in even biology.

At that rate, when you look at the middle schools today, about 75 percent of the teachers in math/science are only temporarily certified because they are not educated and qualified to be certified. Fifty percent in our high schools which are still offering those courses, and they're making a growing demand as representative of the private sector for scientists and mathematicians and others.

That is really a deteriorating baseline, as these figures, after all, like any other statistic, we get immunized in listening to them.

I am very hopeful to have soon developed a comprehensive elementary school program and secondary school program to offer as authorization bills to try to counter this, that have been evolving out of my conferences with the Science Teacher's Associations, the National Science Foundation, and other groups, because that is the real baseline from which we are ultimately going to have to draw researchers.

I think we are going to reach a time, if we do not take some real strong measures, where appropriating an increase of $100 million here for research, what good will it do if there are not the people out there to pick up those grants and to carry on the field of research.

When you look at the growing demands in the private sector, as well as in the medical research field, we are not competing with these people just within one field. You have Hewlett-Packard where over 50 percent of their products in the marketplace today are the result of the last 3 years of research. And they are making a growing demand as representative of the private sector for scientists and mathematicians and others.

So, it is not just medical researchers competing within the various disciplines or diseases, but we are competing in the field of the private sector.

Well, you have heard all this before. I appreciate your raising this problem with us.

Dr. SCANLON. I agree 100 percent with everything you said and we have to start from the beginning. But despite that, at Georgetown and at other schools, the applications have decreased but now they have increased again. We do have programs for the minorities and they are doing very well.

I realize some of these other things you said can project 20 years from now, but at the present time we are putting out the physicians and the scientists in minority groups and nonminority groups, and hopefully this is a good sign.

Senator **Hatfield**. Do you think that there is a special attraction in that particular discipline or do you say that would be true throughout and across all of the disciplines of medical science?

Dr. **Scanlon**. You mean the research?

Senator **Hatfield**. That there is this interest, that there is this application increase?

Dr. **Scanlon**. Well, I would feel that for most people who graduate from medical school, one will want to work directly with patients and be in clinical medicine, and a minority will want to go into research.

Senator **Hatfield**. But does your field represent a special attraction that maybe other fields of medical research would not represent?

Dr. **Scanlon**. Well, it does considering allergy. But also considering immunology. I mean, the immunologic field, this includes allergy. But it includes all conditions. It includes cancer, and it includes AIDS. So, there are many people, yes, that are interested in my particular field, particularly from the immunologic point of view. This is where the answers will be, too.

Senator **Hatfield**. Thank you very much.

Dr. **Scanlon**. Thank you very much.

STATEMENT OF DR. ALFRED A. BAUMEISTER, DIRECTOR, JOHN F. KENNEDY CENTER, VANDERBILT UNIVERSITY

Senator **Hatfield**. Dr. Alfred Baumeister, director of the John F. Kennedy Center, Vanderbilt University.

Dr. **Baumeister**. Thank you, Mr. Chairman.

Senator **Hatfield**. Good morning. Nice to have you here, Dr. Baumeister.

Dr. **Baumeister**. Good to see you. I am Al Baumeister, director of the John F. Kennedy Center at Vanderbilt University, which is one of the 12 national mental retardation research centers. Appearing here, I represent the American Association on Mental Retardation and the Organization of Mental Retardation Research Centers.

As always, we are grateful for the opportunity to share our views with you concerning support through NICHD for children's health problems, particularly developmental disabilities.

I have appeared before this subcommittee every year since 1976 and while my message varies somewhat, there are two points that I have always stressed. One concerns the vast and desperate seriousness of the problem of DD both in human and financial terms.

This year alone we spent about $10 billion on residential services for people with mental retardation. Now, you add to that the high cost of medical, educational, and social services, and you have a sum that some officials in the Pentagon might even notice.

Second, there is no doubt that we have made considerable progress toward prevention and treatment of some conditions. But the scientific data base, knowledge base, is far from adequate to deal with most of the 350 known causes of mental retardation.

I should add as well that many disorders among children are actually on the increase. Such as infant mortality and morbidity, partly due to cuts in services. Increasing risks, new disease such as pediatric AIDS which is now becoming the No. 1 cause of acquired mental retardation, and to societal changes including alarmingly increasing rates of poverty among children.

The administration proposed a budget of $44 million for fiscal year 1990, including $27 million for AIDS research. Under the fiscal year 1990 proposed budget, the funding rate would be 19.7 percent, opposed to 25.3 percent in fiscal year 1989. This would be the lowest funding rate in the history of the Institute.

The Institute operates under a principle called negotiated reductions. That sounds to me like a bureaucratic euphemism for unilateral disarmament of the research community. Nobody admits to a strategy that will sell our children short, but that is what in effect these cuts do.

Our recommendations include the following. Increases to NICHD appropriations in the amount of $584 million to fiscal year 1990. We recommend an amount that will allow NICHD funding of 537 competing grants, a funding rate of 30 percent.

Second, allow additional funds to provide full cost support of the research centers, eliminating negotiated reductions. We urge that the center line be increased by $11 million to enable four new research centers, one learning disabilities center, and three additional mental retardation centers.

And, finally, express congressional commitment to the continuation of high-quality predoctoral and postdoctoral research training by appropriating funds in this category in the amount of $20 million, providing support for 858 trainees.

PREPARED STATEMENT

I would like to say, Mr. Chairman, that a recent study reported in the literature on the age of authors of scientific publications showed that in this field we are now averaging 49. At my point in life I can regard that as a whippersnapper, but I am afraid what that does indicate is a trend in which those of us who are doing the research are not being systematically replaced by a cohort of young talented people supported through research training funds.

Thank you.

[The statement follows:]

STATEMENT OF DR. ALFRED A. BAUMEISTER

Mr. Chairman, my name is Al Baumeister. I am Director of the John F. Kennedy Research Center at Vanderbilt University. Appearing here today, on behalf of the American Association on Mental Retardation and the network of Mental Retardation Research Centers, I wish to express our views concerning FY 1990 federal support, through NICHD, for research on mental retardation and related disabilities.

Mental retardation and the other developmental disabilities typically are life-long handicaps with social, psychological, and biological causes, many presenting extremely severe physical and behavioral consequences. There are over 350 different causes of mental retardation, including genetic conditions, disorders of metabolism, problems of pregnancy and birth, brain damage due to a large number of toxins, accidents, infections, and other untoward circumstances that affect development, such as poverty, undernutrition, and lack of adequate psychological and social stimulation. These are complex and costly problems that will not yield to simplistic solutions.

The human and financial costs to society of mental retardation are staggering. No other human affliction creates so much suffering, for so long, and at such great consequences to the individual, the family, the community, and our nation. There are approximately 6,600,000 persons with retardation in the United States. To provide care and habilitation to the approximately 100,000 persons who resided in public institutions in 1988 we spent about $5.0 billion. The variety of special programs in the community represents an enormous outlay as well, also running about $5.0 billion in 1988. Add to this the enormous educational, medical and social services that must be provided and the cost is awesome, so large that even the Pentagon might be concerned. There are now many thousands of babies who will never have a chance, for even part of their lives, to share in the ordinary opportunities and challenges that we here enjoy.

Because the Congress earlier responded to needs of children, we have made scientific progress over the past 25 years toward the goals of prevention and amelioration. Some research knowledge has been put into practice with outstanding results. As overwhelming as these problems may seem, we have advanced against many of them. For example, we understand the biochemistry underlying a few genetic disorders. We are now able to create medical and environmental conditions for people who only two decades ago who would have been profoundly retarded but who are now able to live normal or near-normal lives. Equally important, studies of behavior and social processes have enabled us to develop effective educationally based procedures that ameliorate many of the learning and behavior problems associated with mental retardation.

Yet we cannot become complacent. We have not solved the problems of developmental disabilities. Far from it. Despite advances in our understanding of mental retardation, the grim truth is that in the vast majority of instances we do not know what specifically causes retardation or how to prevent it. One fact should be made abundantly clear: mental retardation in most cases cannot be traced to a known single biomedical cause.

Indeed, many forms of morbidity among children are unacceptably on the increase, circumstances recently and clearly documented in a nationally distributed publication by the President's Committee on Mental Retardation. As this report points out, Pediatric AIDS is expected to become the leading cause of acquired mental retardation and is currently the 9th leading cause of death among children ages 1 to 4.

Evidence is now overwhelming that living conditions are strongly tied to health outcomes. Between 70% and 80% of the cases of mental retardation are linked to psychosocial disadvantage. In 1986, 13.6% or 32.4 million of our population, including over 20% or 12.3 million of our children, were below the poverty line. As you are aware, minority groups are differentially represented. According to the government's 1986 data, 42.7% or 4 million black children and over 37.9% or 2.4 million Hispanic children under 18 years lived in poverty. Age bias is still associated with poverty. Children are the victims. The 1986 data for poverty rates reveal the following: 22.1% among preschool children, 19.6% among school-age children, 11.1% among adults, non-elderly, 12.6% among the elderly. The life-style patterns and disadvantages that accompany poverty are not wholesome conditions for rearing children. Poverty contributes significantly to birth defects, mental retardation, learning disabilities and other forms of childhood mortality and morbidity. All of these considerations lead to the consensus that we require a much stronger and coherent biomedical and behavioral research base from which to proceed toward treatment and prevention.

Yet, since 1974, commitment to mental retardation research has deteriorated. For 15 years I have conducted analyses of NICHD funding patterns with particular reference to the status of mental retardation as a priority. One general, compelling, and disturbing conclusion emerging from these analyses is that funding for mental retardation research, both in absolute and relative terms, is in a much less favorable position today as compared with 15 years ago. Expressed in constant dollars, our research capability today is much less than half of what it was in 1975. Attached are a table and a figure showing a continuing decline in relative support for mental retardation research, from 1972 to 1988. These tabulations are based on the budget of the NICHD's Center for Research on Mothers and Children (CRMC). This is the primary organizational unit within NICHD that carries the obligation to support mental retardation research.

In FY1989 the appropriation to NICHD was $426 million. But downward negotiations were set at 12.0% for noncompeting grants, 11.4% for competing grants, and 17% for the research centers. This followed on the heels of similar downward negotiations in FY 1987 and FY1988. We do not believe that this is the kind or level of response consistent with either: (a) Congressional intent in creating the NICHD, (b) the gravity of the problem of mental retardation in human and financial terms and, (c) the public welfare. When one considers that the inflation rate exceeded 160% over the past 10 years, we have reached a severe crisis point for research into gravely serious health and social problems.

The Administration proposed an NICHD budget of $444,193,000 for FY 1990. That includes $27,129,000 specifically targeted on AIDS research. Under the FY 1990 proposed budget the funding rate for grants would be 19.7% opposed to 25.3% in FY 1989. This would be the lowest funding rate in the history of the Institute. The President's budget calls for negotiated reductions of 14.2% for noncompeting projects, 10.2% for competing grants, and 17.5% in core support of the research centers. These cuts year after year are destroying our research capability, thereby sentencing more and more children to lives of disability and despair.

We understand, of course, that enormous deficits in the U.S. budget cannot continue and that adjustments must be made. But, reductions in health services, including research, hurt people--children, mothers, families--and the question must be raised: is that what we as a nation intend by way of public policy? This is not some trivial and arbitrary budgetary consideration that will merely inconvenience a few people. Cutbacks of health research capabilities are short-sighted, ultimately very costly, and constitute a grievous disservice to millions of Americans whose health, well-being, and quality of life depend on our government officials and scientists to respond.

SUMMARY RECOMMENDATIONS

We request that the implications presented in our comments be reflected in the narrative report. Improvement of mental retardation services depends on excellent basic behavioral and biological research on prevention, early diagnosis, and intervention. Emphasis needs to be directed toward an expansion of the Mental Retardation Research Centers, additional research and clinical trials in pediatric AIDS, and prevention of low birthweight, infant mortality, accidents, and other childhood disorders. In these respects we lag well behind many other societies.

Our recommendations:

1. Increase funding to NICHD from $425,649,000 in the current fiscal year to $504,037,000 in FY1990. This is in contrast to the Administration request for $444,193,000. The amount we recommend will allow full NICHD funding of 537 competing research project grants at a cost of $113,773,000, a funding rate of 30%.

2. Include additional funds to provide full-cost funding of the research centers, thereby eliminating negotiated reductions. We urge that the center line be increased by $11,000,000 to enable funding four new research centers: one learning disabilities center and three additional centers on mental retardation, allowing for the first expansion in 20 years.

3. Mandate that at least 25% of the extramural support provided by NICHD be for projects directly relevant to mental retardation, including a strong emphasis on prevention research.

4. Express Congressional commitment to the continuation of high-quality predoctoral and postdoctoral research training by appropriating funds in this category in the amount of $20,603,000, providing support for 858 trainees.

Trends in MR Funding*

(Millions of Dollars)

Year	Total CRMC Funds	Total CRMC-MR	MRDD	MRRC Core
1972	42,838,000	21,365,000	17,250,000	5,856,000
1973	41,971,000	21,330,000	16,642,000	6,533,000
1974	51,894,000	23,886,000	18,096,000	5,761,000
1975	55,094,000	25,420,000	18,884,000	5,672,000
1976	60,161,000	27,016,000	20,423,000	5,608,000
1977	64,979,000	28,419,000	21,434,000	6,166,000
1978	73,790,000	30,298,000	23,318,000	6,455,000
1979	102,492,000	35,321,000	28,121,000	6,759,000
1980	101,154,000	34,731,000	27,559,000	6,751,000
1981	106,055,000	32,997,000	26,969,000	6,623,000
1982	105,530,000	31,768,000	25,963,000	6,549,000
1983	123,346,000	35,270,000	29,306,000	7,343,000
1984	135,489,000	35,699,000	29,263,000	7,737,000
1985	157,727,000	44,329,000	36,365,000	9,298,000
1986	158,009,000	47,008,000	36,478,000	8,378,000
1987	190,505,000	54,066,000	42,726,000	9,224,000
1988	213,398,000	59,186,000	46,700,000	9,802,785
Percents of Total CRMC				
1972		49.9	40.3	13.7
1973		50.8	39.7	15.6
1974		46.0	34.9	11.1
1975		46.1	34.3	10.3
1976		44.9	33.9	9.3
1977		43.7	33.0	9.4
1978		41.1	31.6	8.7
1979		34.5	27.4	7.0
1980		34.3	27.2	6.7
1981		31.1	25.4	6.2
1982		30.1	24.6	6.2
1983		28.6	23.7	6.0
1984		26.3	21.6	5.7
1985		28.1	23.0	5.9
1986		29.8	23.1	5.3
1987		28.3	22.4	4.8
1988		27.7	21.9	4.6

*Source of Data: NICHD, Office of Planning and Evaluation

Senator HATFIELD. Thank you, Dr. Baumeister. Dr. Baumeister, you make your comparisons a bit with the military budget. I have often suggested that for just 1 year I would be very happy to trade the Pentagon for the NIH budget. Just 1 year.

Dr. BAUMEISTER. One year would be nice, would it not? Or if we could just auction off a Trident sub.

Senator HATFIELD. That brings us, though, to a very important point I would like to share with you this morning because I think if you went out here and polled the average person in the context of some of these programs, there would be an overwhelming support for that tradeoff for 1 year.

But the problem is that they do not see that in that linkage. As a consequence, those military budgets continue to increase year after year with both Democratic and Republican support in the Congress. It is bipartisan. Whether we have a Republican or Democratic President.

Oftentimes people think, well, there are all of these other programs that they could reduce other than military in order to compensate and raise these spending programs in medical research, not realizing that when we are talking about budget allocations, $550 billion, almost 50 percent—over 50 percent now—of the total budget is in an entitlement field that this Appropriations Committee has no leverage on.

Take another $181 billion—for the interest on the deficit. Then you get to that figure of about $300 billion, which is for the military. And then for all of the other activities of Government, including the NIH, we are at $181.3 billion. Only $300 million more to support all the other activities of Government than we are paying interest on the national debt. Probably in another year we will be paying more interest on the national debt that we are appropriating for funding all the other programs of the Government with the exception of the Pentagon.

Now, when you get down to that particular baseline, I am sure you can appreciate the torque that we go through in trying to find ways to increase, as you have requested here today, some 37-percent increase.

Dr. BAUMEISTER. Yes; I understand that.

Senator HATFIELD. In this one field. In this one field.

Dr. BAUMEISTER. I am reminded of a comment one of your colleagues made last year. He said people here are presenting wonderful cases for increasing funds for what seems to be an infinite number of human problems with a finite budget, and I think most Americans do not understand how much of that budget is already committed in the form of entitlements and deficit reduction, and so on.

So, you are correct, sir. We must make choices.

Senator HATFIELD. But your figures also point out one other thing. Take the GNP—not the budget, but the GNP. Look at the moneys we are expending now for institutional care, for medical support, et cetera, against the money we are investing to try to reduce that part of the GNP cost.

I mean, really, if you want a cost-effective benefit ratio, as the engineers call it in the Corps of Engineers budget, you have the greatest cost/benefit ratio in this dollar than any dollar we appropriate—is in medical research.

Dr. BAUMEISTER. You are correct, sir. I might add that I had the opportunity to present a prevention plan to President Reagan through the President's Committee on Mental Retardation. Every recommendation in there was geared to show that it is cost effective and that if we implement them, we will actually save money as well as lives.

Senator HATFIELD. $1 to $13. We can get $13 back in the economy for every $1 we put in here, in any of these medical research, and all of the medical research programs.

Thank you very much, sir.

Dr. BAUMEISTER. Thank you.

STATEMENT OF DR. TRAVIS THOMPSON, INSTITUTE FOR DISABILITIES STUDIES

Senator HATFIELD. I would like to invite Dr. Travis Thompson of the Institute of Disabilities Studies from Minneapolis MN, and Dr. Thompson, my good colleague, David Durenberger had expected to be here. We are really running a little ahead of schedule. If you prefer to step aside to wait for his arrival or is my notification to you sufficient for you to want to proceed now? It is your choice.

Dr. **THOMPSON**. I think I will proceed now. Thank you very much.

Senator **HATFIELD**. Thank you very much. I am very happy to welcome you, Dr. Thompson.

Dr. **THOMPSON**. Mr. Chairman, I am Dr. Travis Thompson, director of the Institute for Disabilities Studies at the University of Minnesota. I am here to address the fiscal year 1990 appropriation request of the National Institute of Child Health and Human Development.

I am here representing three divisions of the American Psychological Association and an organization called the Association for Behavior Analysis which includes about 4,000 professionals who work to prevent mental retardation and other developmental problems and to develop new treatments for those conditions.

We are grateful for the past support that this committee has given the program at the NICHD for both research and training.

I think, Mr. Chairman, it is difficult for most of us who are not parents of a child with mental retardation to understand how it would feel to see your son or your daughter repeatedly hit their head against a table or another hard surface, or to bite themselves so forcefully that it draws blood and that no matter what you do to try to stop your child from injuring themselves, no matter how many doctors or specialists you go to, you cannot seem to solve that problem.

Well, that is a difficulty that is faced by 41,000 families of youngsters and young adults with mental retardation in America. That includes 400 families in your own home State.

These are not small problems either in human terms, obviously, and they are not small problems in economic terms. It costs seven times as much to serve such an individual as one who does not have those behavior problems but is equally mentally handicapped.

The National Institute of Child Health and Human Development, Mental Retardation Research Center Program is the centerpiece of our national effort to find solutions to just these kinds of problems. These are programs which over the years have already begun to bear practical fruit in solving problems such as self-injury.

During the last sessions this committee saved three of the existing NICHD research centers which were slated for elimination under the administration's budget. Although the centers survived, because of the negotiated reductions which Dr. Baumeister just spoke about, the centers are reeling under the repeated effects of these negotiated reductions year after year after year.

For fiscal year 1990, the administration has proposed another 17.5-percent reduction in core support for these centers. At some point the cost becomes so great that it is very difficult to run a meaningful research program. In fact, these repeated cuts are decimating the national mental retardation research initiative.

Once again, for fiscal year 1990, the administration's proposal falls far short of the need, according to the judgment of our 4,000 professionals as well as the judgment of the agency.

The organizations I represent urge the committee to provide funding to the NICHD, bringing the total number of research centers to 50 and the number of training grants to 858. We also recommend increasing the number of noncompetitive and competitive grant renewals to 1,656 in fiscal year 1990, including AIDS research grants.

PREPARED STATEMENT

In order to roll back the negotiated budget reductions and to establish the three new research centers that are needed, it would require an additional $11 million in the NICHD center line.

We appreciate the opportunity to address the committee concerning these important and pressing matters, and would be glad to answer any questions you might have.

[The statement follows:]

STATEMENT OF DR. TRAVIS THOMPSON

Mr. Chairman and members of the Committee. I'm Dr. Travis Thompson, Director of the Institute for Disabilities Studies at the University of Minnesota. I'm here to address the FY90 appropriation request of the National Institute for Child Health and Human Development. I am pleased to submit this testimony on behalf of the 4,000 members of the Division of Mental Retardation, the Division of Psychopharmacology, and the Division of Behavior Analysis of the American Psychological Association and the Association for Behavior Analysis, a national organization promoting research and applications of behavioral principles to solve human problems. We are grateful for the past support this Committee has provided for the research and research training resources of the NICHD and the opportunity to discuss these issues with the Committee.

Mr. Chairman, it's difficult for most of us to understand how the parents of child with mental retardation or autism feels watching their youngster repeatedly hit his head or bite herself so forcefully that she draws blood. And no matter what they do, they can't seem to find a way to stop their child from hurting him or herself. That's precisely the situation for 41,000 families of people with mental retardation in the United States. These behavior problems are costly not only in human terms, but economically, as well. It costs seven times as much to serve a person with severe behavior problems in a residential program as another individual with a similar degree of retardation who doesn't display behavior problems. That makes services to people with chronic disabling conditions, and especially those involving behavior problems, the most rapidly growing component of the non-defense budget.

The NICHD Mental Retardation Center and Learning Disability Center research programs are the centerpiece of our national initiative to prevent and treat problems such as these. These programs have already paid off richly. Research sponsored under the NICHD Mental Retardation Centers has produced methods for reducing the number one cause of brain damage in children, namely brain injury caused by accidents. Two recent NICHD-sponsored research projects suggest that self-injury can be an addictive process, much as heroin or cocaine are addictive. In these studies a new drug is being tested to block the addictive self-injury cycle. Another NICHD sponsored project has demonstrated that it is possible to prevent serious learning problems and academic disadvantage of children growing up in inner city poverty areas. By applying research-based early educational methods, children growing up in inner city poverty areas have been able to perform at the same levels academically as their suburban peers.

The viability of our national research program in mental retardation, learning disabilities and related conditions depends on training younger scientists in cutting edge research technologies, and to think in new ways about solving problems. The overall research training effort in mental retardation is in jeopardy due to cuts in support for research training. Over the past 10 years, expenditures for training young scientists to work in Mental Retardation and in Learning Disabilities has remained constant, while the consumer price index has increased over 100%, meaning that real dollars for training have been cut in half. Training of behavioral scientists has lagged even further behind.

The Administration's FY 89 budget would have further accelerated the decline in NICHD mental retardation and disabilities research and research training. Thanks to this Committee's support during the last session, it was not necessary to eliminate three of the existing NICHD research centers in FY 89. Though these centers have survived, they are reeling from the effects of repeated annual negotiated reductions. For FY90, the Administration has proposed a further 17% negotiated reduction. These repeated cuts are decimating the mental retardation and learning disabilities research program at the very time the need has become the most acute. Over the past five years the funding rate has dropped progressively, so that only 20% of grants approved by the scientific review groups will actually be funded. Moreover, the actual dollar amounts awarded for mental retardation and developmental disabilities research has dropped by 50% over the period of the program, which is cause for grave concern. For FY 90 the Administration's FY 90 proposal falls far short of meeting the need according to Professional Judgement, and according the judgement of our membership.

The NICHD has increasingly focused its program on issues of direct relevance to solving problems of mental retardation and learning disabilities. We urge the Committee to promote the NICHD movement in a mission-oriented direction by supporting research with brings basic science concepts directly to bear in solving important problems of mental retardation and learning disabilities.

On behalf of the organizations I represent, the Committee is respectfully urged to support the Professional Judgement budget recommendations for the NICHD Research Centers and Research Training, bringing the total number of NICHD Research Centers to 50 and the number of training grants to 858. We also recommend increasing the number of non-competitive and competitive renewal research projects from 1,517 in FY89 to 1,656 in FY90 (including AIDS).

Thank you for this opportunity to address the committee on these important issues.

Recommendations of Dr. Travis Thompson on behalf of American Psychological Association Divisions 25, 28 & 33 and the Association for Behavior Analysis concerning the NICHD FY90 Appropriations Request:

On behalf of the organizations I represent, the Committee is respectfully urged to support the Professional Judgement budget recommendations for the NICHD Research Centers and Research Training:

- funding the total of 50 NICHD Research Centers
- funding 858 training grants
- increasing the number of non-competitive and competitive renewal research projects from 1,517 in FY89 to 1,656 in FY90 (including AIDS).

In addition, we respectfully urge that:

- The proportion of NICHD Center for Research on Mothers and Children funds available for mental retardation and developmental disabilities research be increased to pre-1979 levels with an emphasis on research programs directed at the more immediate and pressing problems of persons with developmental disabilities.

Senator HATFIELD. Dr. Thompson, your testimony is very specific and poignant to the question that you raise about real dollars and CPI increases of 100 percent in 10 years. Oftentimes we get locked into this business of looking at last year's dollar figures and looking at the arithmetic of the budget rather than the actual line of the budgets.

Dr. THOMPSON. That is right.

Senator HATFIELD. That is very helpful. Thank you very much.

STATEMENT OF DR. JEROME GOLDSTEIN, EXECUTIVE VICE PRESIDENT, THE AMERICAN ACADEMY OF OTOLARYNGOLOGY

Senator HATFIELD. I would like to invite Dr. Jerome Goldstein, executive vice president of the American Academy of Otolaryngology. Did I stab it right?

Dr. GOLDSTEIN. You hit pretty well. Senator Hatfield, I am Dr. Jerry Goldstein, executive vice president of the American Academy of Otolaryngology-Head and Neck Survey, an organization which represents more than 8,000 American otolaryngologists.

First, allow me to thank you and Senator Harkin on behalf of our academy members for your leadership in creation of the new Institute on Deafness and Other Communication Disorders. Because of your work, those who suffer from these disorders in our Nation and, indeed, the world community, will benefit.

I come before you today to speak in support of increased appropriations for the new Institute. Dr. Jay Moskowitz and his excellent testimony before you highlighted recent advances which can be exploited to alleviate some disorders and diseases of communication. These include successful restoration of hair cells in the inner ears of some animals, and the development of the cochlear implant.

Additional areas, including balance problems in the elderly, and language disorders among the young, must be explored more intensely.

All of these areas require coordinated research among scientists from many different disciplines. The new Institute will play a major role in effectively coordinating their research. Dr. Robert Ruben of our academy cochaired the task force on the national strategic research plan which contains a complete statement of the opportunities and needs of this new Institute.

The $96 million appropriation recommended in the President's budget is not adequate. Not adequate to carry out the mandate of Congress. Next year, in our professional judgment, the Institute needs funds to increase the number of grants from the 1989 level by 10 percent, to increase the number of contracts, especially those targeted in areas of clinical medicine, to establish national training and research centers as called for in the authorizing legislation, to enlarge the intramural program, and to establish data systems and population based studies and a national information clearinghouse.

As you know, Senator Hatfield, one of the largest problems confronting the NIDCD is the limited number of physicians who are also researchers in the area of communication disorders. Fortunately, some of the brightest and best medical students in this Nation are choosing otolaryngology and see their careers as involving both research and clinical medicine.

We must provide these young physicians with incentives and resources so that they can fulfill their potentials.

Our funding recommendation—there must be ongoing growth to fulfill the mandate enacted in Public Law 100-533. For fiscal year 1990, we recommend the budget for the NIDCD be set at $140 million, which will be well-utilized to carry out the Institute's responsibilities.

PREPARED STATEMENT

Finally, I, both as an individual otolaryngologist and as EVP of the academy, would once again like to thank you and Chairman Harkin for your exemplary efforts behind the creation of this most important institute. Without you, there would be much less hope for rapid advances in communicative disorders research.

Thank you.

[The statement follows:]

STATEMENT OF DR. JEROME GOLDSTEIN

Senator Harkin, members of the committee, ladies and gentlemen: I am Dr. Jerome C. Goldstein, Executive Vice President of the American Academy of Otolaryngology-Head & Neck Surgery, Inc. which represents more than 8,000 otolaryngologists-head and neck surgeons in the United States. We care for patients of all ages who are experiencing problems with hearing, balance, voice, and who have benign and malignant tumors of the head and neck and who have allergic and cosmetic concerns involving these structures.

First, allow me to thank you, on behalf of our Academy members, for your leadership in creation of the new National Institute of Deafness and Other Communication Disorders. Because of your work, those who suffer from disorders in our nation, and indeed, the world community, will benefit.

I come before you today to speak in support of the new institute. The Academy was tremendously supportive of your creation of the NIDCD. This new institute at the NIH reflects a new national awareness of the substantial burden which diseases and disorders of communication place on an individual in contemporary society.

Our ability to communicate affects our well-being throughout our lives, whether as a two year old learning language, an adolescent furthering his/her education, a business person communicating with his/her associates and clients, or an octogenarian enjoying a conversation with his/her great grandchild on the telephone.

Dr. Jay Moskowitz, the acting Director of the NIDCD, in his excellent testimony before you, highlighted many of the scientific advances which have occurred in the past few years which can now be utilized to begin to alleviate some of the disorders and diseases of communication.

These included the recent discovery that hair cells, the tiny sensory cells in our inner ears which are needed for hearing, can be restored after they have been destroyed in birds and some cold blooded animals. This information suggests that we eventually may be able to find a way to repair injury done to human hair cells by loud noises, poisonous substances, infections and genetic factors. As of now, very little can be done to help most people with sensorineural hearing loss. Finding ways to help those with this most common form of hearing disorder will require many highly trained and dedicated men and women who will undertake the extensive scientific investigations involving the sciences of molecular biology, genetics and embryology to extend these observations in birds and other animals to the special circumstances which are present in the mammal, and most importantly, in man.

Another area in which there is significant progress is the cochlear implant. This family of devices has already given aid to several thousand totally deaf people, but the instruments are still in the process of being perfected. This requires teams of specialized Engineers, Speech Scientists, Linguists, Otolaryngologists and Physiologists working together to develop equipment and strategies which will optimize the effect that these implants have. Much of the technology which will be developed will also be applicable to persons with lesser amounts of hearing loss who are now using conventional hearing aides. This endeavor will find application in many different types of communications from telephones to satellites, if there is the person power and the resources to develop the basic technology for compressing information into limited parcels which can than be maximally utilized.

In the elderly, balance disorders account for a large number of falls and consequent fractures of bones. Years ago, many older people died from pneumonia. Antibiotics have changed this. A major cause of death in the elderly today is related to a fall, experienced because of a balance problem. There is a need to find ways of correcting or compensating for these balance problems. We must find a way to keep them from falling so that they can enjoy their maturity. To do this will require cooperative research involving Anatomists, Physiologists, Otolaryngologists and Engineers.

Another area of great societal importance is language. The prevalence and incidence of language disorders appear to be greater than it was here-to-fore expected. Some language disorders are caused by quite modest hearing losses. In some children, even the slightest hearing loss may be associated with a substantial language deficit. Language abnormalities also occur as a result of environmental deprivation. The child with a language disorder has a most serious communication problem and will be unable to achieve his or her economic or personal potential. There is evidence, which needs to be verified, which indicates that many juvenile delinquents and criminals have communication disorders and that many of these are language disorders. Any part of crime which can be prevented by the elimination of language disorders will be a substantive gain for society. The pursuit of this research requires interdisciplinary cooperation between Language and Speech Scientists, Biologists, Psychologists, Sociologists, Epidemiologists and Otolaryngologists.

These are just a few of the important areas which have been identified for a commitment of national research resources. During January of 1989, Dr. Robert J. Ruben of our Academy co-chaired the Task Force on the National Strategic Research Plan for the NIDCD. The Task Force Plan contains a complete and comprehensive statement of the opportunities and needs of this new institute. The NIDCD has come into being. It now must have a chance to develop and grow. The $96,116,000 appropriation recommended in the President's budget is inadequate and insufficient for the NIDCD to carry out the mandate which Congress has given it. In our professional judgement, the institute needs:

1. To increase the number of grants from the 1989 level by 10% (The President's budget calls for a decrease in the number of grants from the 1989 level. There are more than enough applications with high priority scores to reach this goal of an additional 10%. Also, there are new scientists who have been attracted to the discipline because of the excitement of the science and the societal importance of the area.)

2. To increase the number of contracts, especially those targeted in the area of clinical medicine, with a view to looking at the efficacy of various interventions. (These are usually for clinical trials, which are costly, but provide society with an objective evaluation of the best ways to deliver applications of new scientific knowledge.)

3. To establish National Training and Research Centers as called for in the authorizing legislation. (At least 10 of these could be established in the next year.)

4. To increase the intramural program of the NIDCD so that it can undertake both basic and clinical research, serve as a resource for the NIH and provide a superb opportunity for young men and women to work in the exhilarating and intellectually demanding environment of intramural NIH, as called for in the authorizing legislation.

5. To establish data systems and population based studies, as called for in the authorizing legislation.

6. To establish a National Information Clearinghouse for deafness and communication disorders, as called for in the authorizing legislation.

One of the largest problems confronting the NIDCD is the limited number of physicians who are also researchers. The most optimistic estimate is that within this entire country, there are only about 50 physicians who are doing clinical research funded by the NIH in the area of deafness and communication disorders. Most of them are funded by the NIDCD. I personally feel that even this number may be high when it is considered that a number of these physicians have two grants and some of the grants may not be entirely clinical. This is a dangerously low number of physician investigators. Additionally, there is a "greying" of the existing M.D. and Ph.D. investigators in the area of deafness and communication disorders and relatively few young recruits.

It is essential that we actively recruit and train more new investigators to continue the work which is becoming so promising. Fortunately, there are now many young men and women who are undergoing their five years of post-medical school clinical training in otolaryngology who stand ready to fulfill the need for clinical investigators. Some of the brightest and best medical students in this nation are choosing otolaryngology and see their careers as involving both research and clinical medicine. We must provide these young physicians with incentive and resources so that they can fulfill their potentials and assist NIDCD in achieving advances in the cure and alleviation of deafness and other communication disorders.

The establishment of the Research and Training Centers and a stronger Intramural Program will be of aid in recruiting these individuals. The NIDCD administrative staff has already made a contribution to the effort by announcing new programs and by being available to speak with young members of the research community. This effort has already resulted, in my own experience, in more young people orienting themselves to investigatory careers in deafness and other communication disorders. The growing awareness and excitement must be followed up by substantial additional funds for the training of all types of scientific workers in the area of deafness and other communication disorders. This is one of the highest priorities for the new institute.

Funding Recommendation

It is recognized that all of this cannot come about in one year. Over the next few years, there must be ongoing growth to fulfill the mandate which has been enacted in public law 100-533, which created the NIDCD. For the fiscal year of 1990, we recommend the budget for the NIDCD be set at $140,000,000 which will be well utilized to carry out the existing responsibilities of the NIDCD and allow a start to be made in recruiting and training additional investigators.

Finally, I, both as individual otolaryngologist and Executive Vice President of a national medical association, would like to thank you, Chairman Harkin, for your exemplary efforts behind the creation of this most important institute. Without you, there would be much less hope for rapid advances in communicative disorders research.

Senator HATFIELD. Thank you, Dr. Goldstein. Dr. Goldstein, what would you estimate, if you had the funding adequate to meet the need of applicants for research grants in this discipline—what would you guess out there in the medical community, what number of people would be making applications for grants for research?

Dr. GOLDSTEIN. Well, I can answer that several ways. I happen to also be a member of the board of directors of the Deafness Research Foundation. Mr. Meli earlier commented on the over $2 million of seed money grants that they give. Those grants are each $15,000 awards and their intent is to stimulate the interest of young investigators and get them started in this research.

The big turn-off, we fear, is the observation then of these young researchers that so many just do not get funded, and they are turned off to get involved in the process. You know, the estimate is that there are only 50 physician investigators now. Our goal is to see that this is increased to 200 by the year 2000. We feel that the bright candidates are out there and that they will be stimulated by seeing more awards each year.

Senator HATFIELD. You feel that in the process of education today—that is only 11 years away.

Dr. GOLDSTEIN. Right. That is right. We——

Senator HATFIELD. Well, a person could really be—that person would already be in school at this moment.

Dr. GOLDSTEIN. Oh, yes.

Senator HATFIELD. So, consequently, you are saying that on your projected basis, as well as your knowledge of the current market out there—market meaning those who are qualified to apply and carry out a research grant—you do not have any concern necessarily that you could fill—well, how many could you fill today of that 200 that you have as your goal by the year 2000 if money were no question?

Dr. GOLDSTEIN. Well, I think I would have to give you a rather soft answer on that. I would expect another 50 would be a very reasonable number. To double the present number.

Senator HATFIELD. 30?

Dr. GOLDSTEIN. I would say 50.

Senator HATFIELD. 50.

Dr. GOLDSTEIN. It is interesting that there are 245 first year slots in my specialty, otolaryngology, for new residents each year. There are over 500 applicants for those slots. So, the 245 chosen are really the cream of the crop. Many of them have Ph.D.'s in addition to their M.D.'s. These are a very, very exciting group of people who are clearly interested in being involved in research.

Senator HATFIELD. Give me those figures again. You have 245 slots?

Dr. GOLDSTEIN. First year residency students.

Senator HATFIELD. First year residency. And you have how many applying?

Dr. GOLDSTEIN. Over 500.

Senator HATFIELD. Over 500. What will they do, the remaining number that you did not select?

Dr. GOLDSTEIN. Well, that is a real concern. You know, a medical student has less than a 50-50 chance of getting a residency in my specialty. Many of them go into other surgical fields and——

Senator HATFIELD. Lost in other words, in a sense. Probably, for any future return to your specialty.

Dr. GOLDSTEIN. Correct. That is correct.

Senator HATFIELD. Do you happen to know offhand where the slots are available for residency greater than the number applying?

Dr. GOLDSTEIN. Well, I get a lot of phone calls in my position on that, especially from otolaryngologists whose sons did not get matched.

Senator HATFIELD. I am thinking ahead about my daughter. [Laughter.]

Dr. GOLDSTEIN. Well, you had better——

Senator HATFIELD. This is an information session.

Dr. Goldstein. You better get to know a Dr. Shlining out in Portland pretty well. He is a wonderful guy and has a very good program there.

Senator Hatfield. That is very interesting. Thank you very much, Doctor.

Dr. Goldstein. Thank you.

STATEMENT OF DR. CARLO MAINARDI, AMERICAN COLLEGE OF RHEUMATOLOGY

ACCOMPANIED BY MOLLY BURMA

Senator Hatfield. Dr. Carlo Mainardi, representing the American College of Rheumatology.

Dr. Mainardi. Mr. Chairman, my name is Carlo Mainardi. I am professor of medicine at the University of Tennessee, and I am a rheumatologist.

I would like to introduce to you Ms. Molly Burma who is here with me today from Des Moines, IA.

Senator Hatfield. Welcome.

Ms. Burma. Senator Hatfield, it is a pleasure to be here today. It is difficult to represent 37 million Americans with arthritis and to express to you the importance of arthritis funding for arthritis research for myself and my peers.

By telling you some details of my life with arthritis I hope you can understand the importance of adequate funding.

Looking at me here today, I appear to be a healthy young adult. However, that was not the case several years ago. I was diagnosed with rheumatoid arthritis 12½ years ago, at age 19. At age 21 the medication which had controlled my arthritis no longer worked. The next 6 years my life changed drastically.

I had to quit my job. Relationships were broken. I could no longer cut my food, dress myself, or even push toothpaste out of the toothpaste holder.

Because of 6 years of unrelentless daily pain, suicidal thoughts occupied my mind. Then a medication was found that began to control my arthritis and I slowly began to get my life back, a life made possible only because of arthritis research.

It is very discouraging to know research that could benefit over 37 million Americans with arthritis cannot be undertaken because of lack of funds. Therefore, I urge you to provide additional funding of at least $20 million above the President's request for the Arthritis Institute for fiscal year 1990.

Dr. Mainardi. Mr. Chairman, with that background, I would like to emphasize a few points. First of all, it is important to note that the cost of treating arthritis patients has been estimated at about $25 billion. Patients with rheumatoid arthritis are only capable of earning about one-half of their projected income.

This enormous economic burden is borne by society and really can only be reversed by arthritis research. It is our goal to see all patients with arthritis, like Ms. Burma, become gainfully employed and contribute to society. And this really can only be accomplished through the efforts of people engaged in arthritis research.

The National Institute of Arthritis and Musculoskeletal and Skin Diseases unfortunately has lagged behind in its ability to fund competing and new research grants when compared with other Institutes at NIH.

Last year this committee recognized this problem and added $3 million to the fiscal year 1989 budget. For that we are grateful. This permitted us to fund 27 percent of approved grants in the Institute. This is still considerably less than the 35 percent funding level of NIH on the whole.

PREPARED STATEMENT OF DR. JOHN STOBO

Unfortunately, the prospects for fiscal year 1990 are pretty dim. The President's budget would only permit funding of approximately 17 percent of grants which have been approved for funding by a peer review group. As a member of one of those peer review groups, I can assure you that some very high quality research will not be funded at that level.

Therefore, we are asking for an additional $20 million to be added to NIAMS' budget so that we can fund additional research grants.

Thank you.

[The statement follows:]

STATEMENT OF JOHN STOBO, M.D., AMERICAN COLLEGE OF RHEUMATOLOGY

The American College of Rheumatology (ACR) is the world's largest organization of physicians and scientists dedicated to providing leadership in arthritis research, education, and patient care. I appear before the subcommittee today to discuss federal funding for biomedical research, particularly for research on arthritis and related disorders under the purview of the National Institutes of Arthritis and Musculoskeletal and Skin Diseases (NIAMS) within the NIH. But perhaps we should set research itself aside for a moment, just as Congress must do, in order to look at the "big picture":

More than 37 million Americans have some form of arthritis — that translates to 1 in 7 among our friends, neighbors and colleagues. What does this mean for them, and indirectly, for the rest of us? There are of course many implications, as diverse as the people involved. They include the individual costs of pain, limitation of movement and reduced activity, social costs, and other costs affecting society as a whole. The Congress has become increasingly concerned about the economic impact of the diseases and conditions (including arthritis and other joint diseases) which affect American citizens.

In our testimony we will set out specific details of the extremely high economic burden that arthritis and other rheumatic diseases place on this nation. We will then provide information on some of the exciting research activities which are being conducted in this field, the results of which have the potential for reducing that economic burden as they bring us toward better treatments, improved management, and ultimately, cures for these debilitating diseases. Such progress will result in cost savings to society as more complete therapies reduce the number of hospitalizations, limit the need for custodial care, and lower the rate of disease-related worker disability, thereby allowing more individuals to contribute to the economy for a longer portion of their lives, and reducing the economic burden on government, private insurers, and society at large.

THE HIGH COSTS OF ARTHRITIS AND OTHER RHEUMATIC DISEASES

DIRECT MEDICAL COSTS attributable to treatment of the 37 million Americans who have arthritis have been estimated at $13 billion annually, based on Medicaid data (Bloom 1988). A significant portion of this cost is attributable to rheumatoid arthritis (RA), a severely crippling disease affecting between one and two percent of the population. Outpatient costs of treating RA average $1048 per person per year, (including medications, payment for physician services, laboratory tests, and visits to health professionals such as physical therapists). With the cost of hospitalizations and other miscellaneous but necessary expenses—such as transportation for care, hired domestic help and household modifications prescribed by physicians—total direct medical costs average to $2329 per person per year (Spitz 1984). Since 2.1 million individuals have RA nationwide, this means that direct medical costs attributable to RA alone must be close to $5 billion per year.

For example, California's medicaid program (Medi-Cal) projects that the cost of RA for its 24,000 recipients receiving RA treatment is $20.5 million each year. While outpatient care is most common, it accounts for a smaller percentage of Medi-Cal's expenditures than does care provided in other settings. The majority of Medi-Cal's expenditures for RA are directed to inpatient hospitalizations and nursing home services. About 5 percent of Medi-Cal's patients with RA are institutionalized in nursing homes due to this disease. Medi-Cal's expenditures for RA-related nursing home utilization are projected at $6.71 million per year, which amounts to 34 percent of its total RA-related expenditures. Medi-Cal estimates that people with RA have total health care costs more than three times as high as people who do not have the disease and that people with RA are also three times more expensive to insure than those without the disease (Jacobs, 1988). It should also be noted that the $13 billion figure probably underestimates the true expenditure for the direct medical costs of the total population of patients with arthritis, because it was achieved by extrapolating cost data from a sample of Medicaid claim forms to the entire arthritis population. Since a significant portion of the cost is borne by Medicare and other third-party payers (which may pay out at higher rates than does Medicaid), the actual expenditure is probably greater.

When **INDIRECT COSTS** (costs resulting from lost income and reduced productivity) are considered, the costs of all forms of arthritis cost this nation approaches $25 billion each year. For rheumatoid arthritis alone, some specific figures are available for disability and earning losses: About 60 percent of people with RA under 65 who had been working at the onset of their disease become work-disabled, and people with RA earn only 50 percent of their predicted income, based on earnings prior to onset. The "earnings gap" in both men and women of working age between those with and without RA, which is attributable to the presence of RA, is estimated at at least $6.5 billion annually (Mitchell, 1988).

In addition to those who discontinue working, one study showed that another 10 percent decreased the number of hours worked during the study year. Employment-related changes may actually be greater, as individuals may undergo sequential changes in employment in response to progression of the disease (Spitz, 1988). In some cases, family members make employment changes in response to a person's disease: for example, spouses may change from full to part-time work in order to help care for a family member with arthritis. The lost productivity of "care-givers" is often overlooked in analyzing disease-related costs. The financial costs associated with these events are difficult to quantify, but do contribute to the overall economic burden of this disease.

WHAT DOES THIS MEAN FOR POLICY-MAKERS? It's been said that there is no true health policy, only health financing policy. Since the inception of the Medicare and Medicaid programs about 20 years ago there has been a 10-fold increase in per person expenditures on medical care. The source of the expenditure has also changed over time, with the government now responsible for a greater proportion of the expenditure (42 percent) today, than in 1960 (22 percent). The distribution of spending has also changed. Institutions, including nursing homes, now consume one half of all medical care expenditures while providing care to 22 percent of the population (Bloom, 1988). A significant portion of the nation's health care bill is attributable to the cost of treating arthritis and other rheumatic diseases.

BUT THE GOOD NEWS IS THAT BIOMEDICAL RESEARCH IS COST-EFFECTIVE. Right now, research is yielding improvements in treatments for people with arthritis and better management of their diseases. As long as such advances continue to be made, costs to society will decline, as fewer people will have to receive custodial care, fewer disability claims will have to be paid, and as reductions are seen in unemployment and as less disability-caused job displacement occurs. Individuals who previously posed a burden on society will instead be able to contribute to it. For some conditions, this has already taken place: gout, for example, can be successfully managed with drug therapy so that damage to joints does not occur. When mobility is maintained and pain is alleviated, individuals with gout can continue active and productive lives. For other rheumatic diseases, more will have to be accomplished before the full extent of long-term cost savings can be realized. The devastating disease lupus represents an exciting opportunity in which advances made possible through research can reduce the high toll this disease takes in terms of human suffering. Lupus has become better recognized and improved diagnostic tests now provide important information which allows physcians to tailor managment of the disease to the individual patient. Further efforts must be supported so that the many individual and societal burdens associated with lupus can one day be completely eliminated. The prerequisite for progress is an accelerated research agenda, which directly depends on Congressional support for increased federal funding for bio-medical research.

OPPORTUNITIES IN ARTHRITIS RESEARCH

Rheumatoid arthritis is characterized by the chronic inflammation of the lining of the joints, which often leads to irreversible joint destruction. The majority of people with RA are treated with a wide range of nonsteroidal anti-inflammatory drugs (NSAIDs), and other medications which are capable of affecting the course of the disease, and in some cases, causing its remission. However, some people with RA develop severe joint destruction that does not respond to conventional treatment, and new kinds of therapy must be sought. For example, research is underway to find out more about how cyclosporin A may be effective for these patients. More research on the toxic effects of this drug could bring us to the day where more individuals could benefit from this regime. If this is the case, we can expect costs to be lowered as fewer hospitalizations are required (both for the disease and for its side effects) and as more individuals can continue in productive lives.

Certain clinical observations have suggested that the nervous system plays a role in the development of rheumatoid arthritis: for example, individuals paralyzed on one side of the body who then develop rheumatoid arthritis have either no arthritis, or less severe arthritis on the paralyzed side. Recently, NIAMS-supported investigators demonstrated that a small protein produced by nerve endings, called "substance P", stimulates proliferation of the cells lining the joint cavity and promotes inflammation. Knowing the precise role of substance P in RA is likely to be crucial in future efforts focused on improved treatments for people with RA. Ultimately, more precise management of RA will facilitate continuance in activities of daily living for these individuals, allowing them to continue to be productive members of society.

Osteoarthritis, (OA), (a common form of arthritis), primarily affects cartilage—the protective material that covers and cushions the end of the bones—causing it to fray, wear, ulcerate, and, in extreme cases, to disappear entirely, leaving a bone-on-bone joint. Disability results most often from disease in the knees, hips, and spine. Determining the amount of cartilage damage that has occurred in people with OA is a key step in OA's diagnosis and treatment. A link between the main component of cartilage (type II collagen) and cartilage destruction is suspected because type II collagen has been found in the joint fluid of people with OA and RA, but not in normal joint fluid. The demonstration of type II collagen in joint fluid may prove to be a sensitive indicator of early and progressive cartilage destruction. This could have enormous impact on disease management: early diagnosis with appropriate treatment, can reduce the long-term degenerative effects of these two diseases, which have the most costly consequences in terms of public and private financial burdens.

NIAMS' LEADERSHIP, AND ACR'S FUNDING CONCERNS

The NIAMS is providing leadership so that these and other important research opportunities can be explored. However, with regard to the budget situation at NIAMS, we regret that we have much the same message to you this year as we did last year. Namely, that since its creation as a separate institute in 1986, the NIAMS has had inadequate funds to support the particularly large number of very high-quality research proposals it receives. Compared to other institutes within the NIH, the NIAMS supports a much smaller percentage of high-quality grant proposals which have been approved by peer review groups for funding. In 1987, an average of 38 percent of approved competing research projects could be funded NIH-wide; the NIAMS could fund only 31 percent. In 1988, the NIH-wide average dropped to 35 percent, but the NIAMS award rate was only 28 percent for that year.

For fiscal year 1989, Congress recognized NIAMS' inability to fund a sufficient amount of research proposals due to severe fiscal constraints. Thanks to the fine leadership of this subcommittee, the NIAMS received a $3 million add-on to address the disparity in funding for competing research project grants. This will increase the award rate for NIAMS to about 27 percent which approximates the NIH-wide average for FY89. Had it not been for Congress' willingness to provide this add on, the NIAMS award rate would have instead continued its downward decline to about 24 percent last year.

Because of the severely restricted funds in the Administration budget plan for FY 90, we must ask the subcommittee to do substantially the same thing it did last year, for exactly the same reason: Under the President's request, NIAMS will only be able to fund 17 percent of competing research grants. The total number of research project grants will drop only slightly under the FY 90 projection (647 grants compared to 658 in FY 89). However, the number of new and competing grants within this number will be almost one-third fewer than last year. For new and competing grants the researcher has less than a 1 in 5 shot of having his/her approved grant application funded. To make matters worse, he or she must anticipate a 10 percent cut in the size of his grant below what the study section recommends, even if it is funded.

Although ACR believes that research project grants form the cornerstone of the biomedical research enterprise, we are also very concerned about research training which is absolutely essential for manpower development, especially in clinical research. Physician scientist awards are critical in order to ensure that physicians are trained in the areas of molecular genetics, immunology, and cell biology. Under the Administration's plan, fewer of these essential awards would be made in FY 90 than in any previous year. In contrast, our funding recommendation would allow 11 more awards to be made than in the current year. There has been a significant downward trend in funding for research training. A dearth of trainees has been identified specifically in the area of pediatric rheumatology, which we believe is particularly troubling. It is essential that we have a core of well-trained young investigators who can provide a necessary infusion of new ideas in basic and clinical research. If the current trend continues, the ability of the U.S. to remain at the forefront of biomedical research will be jeopardized. Clinical trials are the essential pathways by which research is brought from the laboratory to practical applications. The NIAMS' current funding level can support only a few of the opportunities which are now available. Several new trials, including a major clinical trial on treatment of the late stages of Lyme disease, have been identified for funding, if sufficient support is provided.

We hope that the Congress will continue to take an interest in the development of NIAMS' intramural program. Last year, an ad hoc advisory panel met and recommended several areas of basic and clinical research to further the intramural program. As a result of the expansion of Building 6 on the NIH campus, the NIAMS was provided with 8,000 square feet of new laboratory space. In order to capitalize on this, increases in both funding and in FTEs will be needed. We feel this is an important goal, especially in the important areas of connective tissue biology and structural biology which are now ready to be implemented.

The ACR is concerned that as a result of an inadequate federal commitment to research, talented scientists will be discouraged from careers in research, and those now in academic research will be forced to choose other pursuits. With regard to the NIAMS, the funding problem is particularly obvious, since researchers are tending to move their proposals into other areas where funding constraints are less severe. A "critical mass" of trained research scientists must be maintained if we are to continue making advances which can ultimately improve patient care, and if this nation is to continue as a leader in the bio-medical research enterprise.

For individuals who have rheumatic diseases, the consequences of inadequate funding are even more devastating: For those of us blessed with good health, it is very difficult to fully comprehend what it means to have such a large amount of research which could result in improvements in people's daily lives essentially lost. Moreover, because of the cumulative nature of biomedical research, when a given project is not funded, the products of that research are lost, as well as the products of any other research opportunities which might have been built upon it.

In light of the long-term cost savings to society which can be made possible by the results of research, inadequate funding is fiscally unwise for the nation: Since the mid-1980's, the level of federal commitment to biomedical research might be characterized as "penny-wise, but pound foolish." For example, it has been estimated that control of osteoporosis could be achieved in about 20 years if our yearly research commitment (about $20 million) were doubled. Given that this disease costs the nation annually $7-10 billion in health care costs and lost productivity, the relative benefit of an increase in our commitment to research is clear from the numbers, alone. Much the same results could be yielded for other diseases, including arthritis and related disorders, if adequate funding is provided.

CONCLUSION

The College has deliberated on funding matters extensively, with particular attention to concerns about the national deficit and the budgetary constraints facing Congress. Because adequate federal investment in biomedical research will reduce costs to society in the long run, ACR actively pursued efforts at the Budget Committee level aimed at increasing the overall amount for discretionary health programs. We are aware that the sub-committee must struggle with limited funds for many important programs. For this reason, we simply ask that you do as you did last year, namely recognize the funding disparity at NIAMS and take whatever action is possible to rectify it.

Our recommendation to you is that $23 million more than the Administration's request be afforded to NIAMS. The resulting funding level ($191.9 million) is not sufficient to fully support all the scientifically sound research which now exists within the purview of the NIAMS. It is, however, enough to build upon your efforts of last year to bring NIAMS into line with the rest of NIH. It is also enough to begin to support a more reasonable amount of the valuable research on these debilitating disorders which will be absolutely essential if we are to achieve both long-term cost savings for society, and improvement in the quality of life for people with arthritis. We strongly support whatever efforts you can take again this year to augment the NIAMS' proposed funding level for FY 90.

Senator **Hatfield**. Thank you very much. You are sort of like the new kid on the block, are you not, in terms of the relationship to the other institutes. You were the youngest, the newest up until the formation of the Institute on the Deafness.

Dr. **Mainardi**. That is correct.

Senator **Hatfield**. Of course, you have to develop, I suppose, the seniority and the clout to get the funding levels because there is no question your funding level has lagged and the need is very demonstrable.

Just out of curiosity, have you done any work with Dr. Stanley Jacob and DMSO?

Dr. **Mainardi**. No; I have not.

Senator **Hatfield**. You have not. You are aware of DMSO?

Dr. **Mainardi**. Yes; yes, we are. It has been studied.

Senator **Hatfield**. It has helped some. Controversial.

Dr. **Mainardi**. Yes; it is controversial.

Senator **Hatfield**. Upgraded and out of veterinary practice.

Dr. **Mainardi**. Well, it is apparently quite effective in veterinary practice.

Senator **Hatfield**. Although you will not find a single athletic department that does not have it and uses it.

I appreciate very much your testimony and, again, I know I speak for Chairman Harkin as well as for myself because, very frankly, I feel we are very fortunate to have a person like Senator Harkin chairing this subcommittee on appropriations. He is very devoted to the needs as well as to the programs of delivering those needs to people in medical need. So, I will certainly assist him in every way possible in matters of developing higher levels of funding.

I must say in all objectivity, the administration over the years have been fairly consistent in not reducing the NIH budgets as much as many other budgets that have gone through the ratcheting down process. In 8 years, from 1981 until 1989, we basically reduced all of those nonmilitary programs by about 33 percent in that category of discretionary programs.

NIH was not really the recipient of a lot of that ratcheting down because it has a strong basic support in the leadership of this committee, both Democrat and Republican, and also in the administration.

That does not mean that we have not lagged in the levels of need. Certainly, as you measure the need, it justifies not just holding the line but certainly moving ahead.

The tragedy that I see so often is that we are on the brink, so to speak, of a number of these programs where breakthroughs could occur by just a slight acceleration. Some, a more major acceleration.

I just feel that we have so much hope in these fields, whereas in some other areas we are just holding the line, and doing well to do that I suppose. In other programs besides medical research.

Dr. **Mainardi**. Much has been said this morning about attracting young people into research. I would like to add that if 1 in 6 or 1 in 7 approved grants are being funded, that provides a tremendous negative incentive for young people to come into research. They perceive the research community as banging their heads up against the wall, to put it bluntly.

Senator **Hatfield**. That is an interesting perspective. Thank you both for your testimony.

Dr. **Mainardi**. Thank you.

STATEMENT OF DR. LEWIS P. ROWLAND, AMERICAN ACADEMY OF NEUROLOGY

Senator **Hatfield**. I would like to invite Dr. Lewis Rowland, American Academy of Neurology.

Dr. **Rowland**. Senator Hatfield, thank you for allowing us to come. I am Lewis Rowland. I have been a chairman of a neurology department for 22 years, first at the University of Pennsylvania and since 1973 at Columbia Presbyterian Medical Center in New York.

Senator **Hatfield**. You must know Dr. Zimmerman.

Dr. **Rowland**. Harry Zimmerman?

Senator **Hatfield**. Out at Oregon.

Dr. **Rowland**. Oh, Earl. Earl. He was in our department. I knew Earl when——

Senator **Hatfield**. University of Pennsylvania.

Dr. **Rowland**. One of my best friends. A wonderful person.

Senator **Hatfield**. Yes; he has done a great—excuse me—take off the light, I will not count this against you.

You probably have heard some rumors on it. He has done some amazing work already in bringing together the university program in neurology with one of the local hospitals that has an institute of neurological research, Good Samaritan.

Dr. **Rowland**. Right.

Senator **Hatfield**. And Bob Dow. You must have heard——

Dr. **Rowland**. Very well.

Senator **Hatfield** [continuing]. Of him over the years. And John Raft——

Dr. **Rowland**. Right.

Senator **Hatfield** [continuing]. And some of those others. Also, with the new replacement for the veteran's hospital out there, and now having undertaken a research program in conjunction with the veteran's hospital, they now have about $5 million in research in neurology.

So, taking those three units of resources and bringing them together under sort of an institution without walls and coordinating their efforts, it has taken some very outstanding leadership and Dr. Earl is the only one who has done that for us.

Dr. **Rowland**. It is a wonderful opportunity and you have wonderful leaders.

Senator **Hatfield**. Thank you. Now we will start your time.

Dr. **Rowland**. One more autobiographical statement. My own research has been in neuromuscular diseases and that includes amyotrophic lateral sclerosis, the disease that was fatal to Senator Javits. So, I am familiar with that kind of tragedy.

I appear today on behalf of the American Academy of Neurology, an organization of 10,000 members, supporting the budget of the National Institute of Neurological Diseases and Stroke for fiscal year 1990.

Neurologists are confronted with many important diseases that account for tremendous amounts of human tragedy at a tremendous economic burden to the country. For instance, Alzheimer's disease costs the country $50 billion a year.

Senator **Hatfield**. $50 billion now?

Dr. **Rowland**. $50 billion is the estimate.

Senator **Hatfield**. It was just $30 billion, you know, a couple of years ago.

Dr. **Rowland**. Well, in terms of time lost and cost. Stroke affects 500,000 Americans each year, at an estimated cost of $13.5 billion, and we could go on down the list.

Now, we are faced with these tremendous challenges at a time when there have been absolutely fantastic advances in neurosciences, and some of these are detailed in our brochure that was prepared at the request of the House Appropriations Committee to support a House bill called the Decade of the Brain because we believe that an increased effort in the next 10 years could pay off tremendously in terms of these diseases.

Among them are transplantation of pieces of the brain, which Dr. Zimmerman himself was a pioneer in. Imaging that is beyond belief, and advances in DNA for genetic diseases have been tremendous.

Now, among those DNA advances are two neurological diseases. One is Huntington's disease which affected the folk singer, Woodie Guthrie, and another one is Duchenne muscular dystrophy, the kind that is fatal to young boys.

We believe that there are genetic contributions to Parkinson's disease and Alzheimer's disease too, and they could go on.

So, we think that there should be a movement to take advantage of these opportunities. Instead, we are faced with an administration budget that would give us 117 fewer competing grants than we have already, a 21-percent decrease.

Within a few weeks I will be going to the NINDS Council, and I tell you, it will be a dismal session to think that one out of five approved grants may be funded—one out of five—unless there are more cuts in existing grants, which create havoc with what we have already.

Now, there has been discussion before about research training, and I am afraid I agree with the previous speaker who is concerned about the future of research as a career because young people, when they see their professors writing applications all the time because their approved grants are not funded and they have to reapply and turn to different sources, they say, what are they doing? What kind of a job is that for a smart person?

The second thing is that the cutbacks in recent years have severely affected training programs. So, we are asking for an increase in that.

The third issue of contemporary importance is the need for clinical trials. It is needed to translate the research laboratory advances into human terms, and it will be needed to help control the costs of medicine too, to pick appropriate treatments and stop wasting money on ineffective treatments.

PREPARED STATEMENT

So, we need an infusion to do both basic research and clinical research and clinical trials. For that, we have requested a budget of $616 million for fiscal year 1990.

Thank you very much, Senator. I would be pleased to answer any questions.

[The statement follows:]

STATEMENT OF DR. LEWIS P. ROWLAND

The brain is the body's most complex organ. Diseases of the brain are numerous and varied. For those without a neuroscience background, names such as neurofibromatosis, spina bifida and myasthenia gravis may seem too complicated to grasp. But did you know that brain research also addresses high-visibility issues, such as drug addiction? For example, understanding the basis of addiction might ultimately be applied to society's interest in stopping drug abuse, as treatments are developed which can break the "craving" for drugs by preventing the brain-mediated "high" which some drugs produce.

Mr. Chairman, ninety-five percent of what we know about diseases of the brain has been learned in just the last ten years. The field of neurogenetics is probably the single most important area of inquiry in neuroscience research, today. One quarter of all known genetic diseases are neurological diseases. Already many advances have been made in the fight against some of them, including such severely debilitating and life threatening conditions as Huntington's disease, Parkinson's disease and Duchenne muscular dystrophy. Alzheimer's disease, which is probably a group of related conditions (or "syndrome") rather than a single disease, has been found, in some cases, to have a genetic basis as well. With an expanded research effort in the area of neurogenetics we can expect that these diseases can be conquered. Given the high costs of neurological diseases, in economic terms as well as in human pain and suffering, the American Academy of Neurology believes that major efforts should be expended to achieve better treatments and cures within this decade. The American Academy of Neurology (AAN) is an association of over 10,000 neurologists and neuroscientists throughout the U.S., and world-wide. As President of the Academy, I am pleased to have the opportunity to provide to the subcommittee our recommendations on brain research and related funding.

SUCCESSES WARRANT ADDITIONAL SUPPORT

The National Institute of Neurological Diseases and Stroke (NINDS) is the primary governmental unit providing leadership to researchers investigating the causes, treatments and potential cures for neurological diseases. The number of exciting research accomplishments in the area of neurogenetics alone documents the importance of the NINDS, and strongly supports our contention that federal funding for research on neurological disease should be increased. The following is just a sample of some of these accomplishments:

This year alone, 11 new markers for the Huntington's disease gene have been located. With these new markers, testing for Huntington's disease, before symptoms appear, is over 99 percent accurate when tissues from sufficient family members are available for study. The pursuit of additional markers for the Huntington's disease gene will continue, aimed at defining its precise location. Presymptomatic testing will thus be improved even more. Ultimately, the cloning of the Huntington's disease gene and identification of its products will lead to a full understanding of how the illness is caused, as well as to possible treatments.

Great strides have been made recently in characterizing the gene which is responsible for Duchenne muscular dystrophy. The protein product that the normal gene produces has been discovered (dystrophin). This protein is present in small quantities in normal muscle cells, but is missing in muscle cells of Duchenne muscular dystrophy patients. Knowledge of the structure and function of this protein and its metabolism will enable us to develop therapeutic techniques.

Another gene defect has been localized on chromosome 21 in four large families with a familial form of Alzheimer's disease. Further analysis of chromosome 21 will be pursued in order to construct a "map" which better defines the precise location of the gene or genes which may be responsible for familial Alzheimer's disease.

When additional research information is considered in the areas of traumatic head and spinal cord injury, stroke, and epilepsy, one can easily see what a "full plate" of research opportunities awaits us, if we have Congress' support. Toward that end, a resolution has been introduced under the leadership of the ranking member of this subcommittee, declaring the 1990's the Decade of the Brain. You have heard much about this resolution; and properly so, as our 10,000 members feel that this is a very high priority issue. But let me share with you my own personal thinking with regard to this resolution. I believe that it is only one half of a two-pronged attack, and both halves are needed to effectively wage the battle against neurological diseases. The Decade of the Brain resolution is the half which raises consciousness about the enormity of the problem and educates the public about the research which is being conducted. This is very important, and thanks to the leadership of Mr. Conte and all of you on the subcommittee, we are near to reaching this goal. It is, however, the second aspect that I want to discuss with you today, and that is increased funding for neurological research. If increased funding isn't available the Decade of the Brain is essentially meaningless. If there is to be a realistic federal role in the fight against neurological diseases, both awareness and increased funding are required. Ideally, 1990 should be the first year of a decade-long commitment to wipe out neurological disease as a major national medical problem. The cornerstone of such a commitment must be adequate federal funding for neurological research and we are asking for your help in achieving this.

NINDS: THE FUNDING IMPERATIVE

In contrast to our research goals, the Administration's budget for FY 90 would actually support less neuroscience research this year than last. An enormous amount of important research opportunities will be lost, unless Congress acts. The Administration's request for NINDS for FY 90 is just under $502 million, including AIDS. This is an increase of less than 5% over the FY 89 appropriation (adjusted for the removal of activities under the purview of the new deafness institute). This is not even sufficient to keep pace with inflation. Several different NINDS funding mechanisms are of particular concern to the Academy.

For research project grants, which neuroscientists feel are the mainstay of our national research effort, the administration is requesting only $15 million more than last year. This would mean the following: a total of 1956 research project grants would be funded, 78 fewer than last year. For competing research project grants 117 fewer could be funded than in FY 89—a 21% decrease. In contrast, we recommend funding for NINDS which would allow 2200 research project grants to be supported in FY 90, including 140 more competing grants than in FY 89. NINDS expects that this funding level would allow it to fund about 50% of the grant proposals which have been approved for funding by study sections. Perhaps even more importantly, it would allow grants to be funded at levels recommended by the study sections rather than at levels which have been cut by as much as 10 percent. Such reductions significantly hinder researchers who may be forced to cut back in technical staff, equipment, or supplies, with the ultimate effect of slowing the pace at which research can be accomplished.

Clinical trials are the essential avenue through which research advances made in the laboratory can be translated into patient care. Research & Development Contracts are the major mechanism of support for clinical trials, and allow control in clinical interventions to be much more precise than is possible in other funding mechanisms. However, clinical trials are by nature comparatively expensive research activities. With funding constraints as tight as they are, NINDS is now in the difficult position of denying sufficient support for traditional research grants, in order to fund important clinical trials. The Academy feels that this situation will have a negative impact on our ability to continue to make advances in the war against neurological diseases, unless it is corrected.

NINDS's agenda for FY 90 includes clinical studies in the following important areas:

- Development and conduct of a clinical trial on the role of anti-clotting agents is being encouraged: These agents (called heparinoids) may prevent worsening of the brain injury after some strokes by preventing the continued formation of blood clots. The opportunity to determine whether the extent of disability after a stroke can be reduced by treatment with heparinoids must not be missed.

- The first critical evaluation of two promising new drugs is now being conducted in a double-blind, placebo-controlled clinical trial on acute spinal cord injury.

- A longitudinal study of a large sample of infants will examine the neurodevelopmental consequences of neonatal brain hemorrhage. Infants with neonatal seizures are being intensively followed from birth to age two years in order to identify the characteristics of those who will develop severe mental and/or motor deficits. The effectiveness of the drug indomethacin will be studied as a means of preventing intraventricular hemorrhage in very low birthweight infants, and as a means of reducing the severity of hemorrhage once it has occurred.

- Another clinical trial is underway to determine the optimal dosage of adrenocorticotropic hormone (ACTH) in infantile spasms. ACTH treatment is known to quell the progressive course of spasms which can result in mental retardation. The trial will also assess long-term effects of ACTH therapy.

It is the Academy's position that research project grants and clinical trials are each indispensable components of a concerted and cohesive effort to make progress against neurological diseases. The beneficiaries of neurological research should not have to be deprived of the fullest possible benefits of either of the two, based on funding shortfalls. We believe that an infusion into the NINDS budget is needed to support clinical trials without depleting needed resources for research project grants. In its deliberations on the NINDS budget, we urge the subcommittee to strongly consider this approach.

Data from a number of sources, including the National Academy of Sciences and the National Science Foundation indicate a current shortage of certain types of biomedical scientists, and suggest that greater shortages are possible in the near future. A shortage of physician investigators exists in the clinical fields of neurosurgery, neurology, and neuropathology. Our funding recommendation will provide for a 5% increase above FY 88 training levels (prior to the stipend increase). This is desperately needed now, in order to begin to recruit a core of qualified young researchers. Without it, the U.S. is likely to lose its ability to remain at the forefront of neuroscience research. But more critically, those who are afflicted by neurological diseases stand the most to lose. As you know, it takes many years to fully train research scientists in many fields, including neuroscience. We have a responsibility to see that a sufficient number of scientists enter the pipeline now, in order to assure that future generations will see the kinds of progress we have seen, and hopefully more.

The Report of the Interagency Task Force on Head Injury (to which the Academy contributed its testimony) will be released imminently. That report, which was mandated by Congress, will detail the enormity of the problem of Head Injury for the first time. It will also conclude that this nation is less than fully prepared to address it. Regional research centers which would provide clinical care to head injury victims are recommended in the task force report as one way to begin to better cope with head injuries in this country. However, there is no money in the Administration's plan for FY 90 for these regional centers. In contrast, our recommendation includes sufficient funds to allow this initiative to be started in this fiscal year.

OPPORTUNITIES FOR THE FUTURE

As you can see, a great many successes have already been achieved in research areas under the purview of the NINDS. For the future, a variety of promising findings are opening the doors to new areas of inquiry. For example, in the study of Huntington's disease, drugs that attenuate neurotoxic effects will be tested to assess their ability to retard neural degeneration and clinical decline. Correlations between the age of onset, rate of progression, and neurodegeneration of the brain should be explored, and behavioral manifestations of the disease—such as anger, depression and manic symptoms should also be examined and compared. In Alzheimer's patients, the finding that those with the disease have greater difficulty recalling objects than remembering locations should be used to amass a behavioral profile for the disease that can aid clinicians in diagnosis.

Advanced imaging techniques now allow scientists to look at the inside of the human brain on a computer screen rather than through surgery. Changes in brain structure and metabolism during the course of neurological diseases can be examined more fully, as imaging methods continue to be developed and refined. For Alzheimer's, Parkinson's and Huntington's diseases, imaging techniques have the potential of giving us a clearer picture (literally) of the disease and a better understanding of processes and its progression.

CONCLUSION

The Academy recommends funding of $616 million for NINDS for FY 1990. The devastating and costly neurological diseases which affect millions of Americans warrant an all-out attack, and the opportunities available in neurological research are so far-reaching that we feel a substantial funding commitment is justified. In fact, we believe that it is more than justified, it is absolutely essential if we expect progress to continue. Ninety-five percent of what we know about the brain has been discovered within the last ten years. If an adequate investment in research is provided right now, the possibilities are almost limitless with regard to what can be learned and what can be achieved in the next ten years.

To say that the brain is unique is an understatement. It is, of course, the body's "command-center". When other parts of the human body are not functioning, scientists and physicians can approach them directly. We have dialysis when kidneys fail, and today liver and heart transplants are becoming more frequent. But not the brain: cessation of its function means death. The dysfunctions of the brain, however, represent a unique opportunity for us to use a variety of emerging medical applications to benefit millions of American's lives, relieve suffering, and reduce enormous costs to society which result from neurological diseases. Today, science can, and should, aggressively attack neurological diseases. However, this can only be achieved by increasing federal funding for neuroscience research. We urge the subcommittee to take all possible steps to ensure that the 1990's is the Decade of the Brain, in fact, as well as in name.

Senator **HATFIELD**. Thank you, Dr. Rowland. Again, it is going to present a dilemma for the chairman of our subcommittee, Senator Harkin, and the rest of us on the committee to respond to a very legitimate request.

You heard them before your testimony this morning, and they go on and on and on. And every one of them, I feel, has been well thought out and very legitimate requests. Now, to try to accommodate the request levels of spending will be our problem. It will not be an easy one, as you know. But it is not because we would not want to respond.

Some 616, for what it could do in terms of reducing the other costs in our society, to treat and deal with those diseases, is a very small amount. But I know Senator Harkin and the rest of us will do our very best.

Dr. **ROWLAND**. Thank you very much, Senator.

STATEMENT OF DR. PEYTON WEARY, AMERICAN ACADEMY OF DERMATOLOGY

ACCOMPANIED BY BARBARA MATIA, PARADISE VALLEY, AZ

Senator **HATFIELD**. Dr. Peyton Weary of the American Academy of Dermatology.

Dr. **WEARY**. Thank you very much, Senator Hatfield. I am Dr. Peyton Weary. I am presenting this testimony on behalf of the American Academy of Dermatology and the Society of Investigative Dermatology.

It is always a pleasure for me, Senator, to be able to come and show you visual evidence of how the moneys that you appropriate have actually resulted in improved patient care, and I would like to come up and show you something.

You have previously heard testimony on behalf of the National Congenital Port Wine Stain Foundation about the need for research in this disorder which is so disfiguring. In February of this past year a report appeared in the New England Journal of Medicine indicating a very substantial new improved treatment for this condition using the Tunable Dye Laser. This research was done through money appropriated for the National Institutes of Health.

I would like to show you some pictures, if I may—here is the article, and here are some pictures of before and after, showing what this can do. Actually, it has completely eliminated that disfiguring problem. Here, another patient, to show you the same sort of change, and yet another one, a very small infant.

So, you can see that we are already using the money that you appropriate for a very important type of improved patient care.

Senator **HATFIELD**. And you could help Mr. Gorbachev.

Dr. **WEARY**. Mr. Gorbachev certainly would be able to be helped. It is interesting to speculate how far he might have gotten if he had that treatment earlier. [Laughter.]

Senator **HATFIELD**. Well, that may be something that we can offer him as a return for reduction of arms.

Dr. **WEARY**. Well, as a matter of fact, you might be interested to know, Senator, that the individuals at Boston have already written to him and offered him this treatment.

Senator **HATFIELD**. Is that so? Well——

Dr. **WEARY**. He has not responded yet. Senator, we are very appreciative to the Congress for the increased support that they gave last year to the National Institute for Arthritis and Musculoskeletal and Skin Disease with the add-on of $3.1 million.

However, we would direct your attention to the fact that this Institute is still significantly underfunded and that the award rates are still below the NIH average, and the paylines are also below the NIH average, which indicates that the grants are still a very high level, highly competitive in comparison with the NIH average.

The President's proposed budget of $168.6 million would only probably support 17 percent award rate in 1990 for the approved grants, and we believe that this is inadequately funded. It was woefully inadequate. We would propose a figure of $192 million for this Institute for fiscal year 1990.

Now, I have also presented testimony on behalf of a number of other institutes, but there is one in particular that I would like to direct your attention to. It is not an NIH institute, Senator; it is the National Institute for Occupational Safety and Health.

Earlier you raised the issue of the fact that in order to be cost effective research can oftentimes improve loss of productivity in society. Here is a very good example because loss to industry in productivity for occupational diseases is very significant. We feel that this Institute has been woefully underfunded for many years and we were shocked to see that the President proposed a funding level of only $45 million down from $70 million.

PREPARED STATEMENT

We not only think that that should be rejected, that low level of funding, but that actually this Institute has been underfunded and should be substantially increased.

Thank you very much.

[The statement follows:]

Without those additional funds the award rate for this institute would have fallen to 24% rather than 27% for FY 1989.

We are still concerned about the level of funding for the NIAMS, however, since the award rates are still way below the NIH average, and the paylines are also substantially lower indicating that the quality of the grants remains very high indeed in comparison to the NIH average. If the President's proposed budget for FY 1990 of 168.6 million dollars were to be adopted we anticipate the award rate for FY 1990 would fall to an unbelievably low level of 17% and the number of trainees would remain at a distressingly low level of 194 as in 1989 (down from 238 in 1988). Furthermore, we in the dermatologic community have particular concern about the inadequate levels of funding for the NIAMS since, of the six core centers for skin disease research which the Congress supported in concept in 1988, only two have been funded to date because of the severe budgetary shortfall in other categories. The diseases for which the NIAMS supports research are for the most part debilitating chronic diseases which sap the strength and vitality of our population, and at enormous cost. Improved treatments for such diseases will alleviate suffering, and reduce the economic burden of illness in our society.

Mr. Chairman, we support the recommendation of the Coalition of Voluntary and Professional Associations Concerned with the Programs of the National Institute of Arthritis and Musculoskeletal and Skin Diseases for a funding level of $192 million for FY 1990, to bring the level of support for research in this impacted institute to a semblance of parity with the other NIH institutes. The statement of this coalition is appended to this testimony as Appendix A.

Once again, Mr. Chairman, the American Academy of Dermatology and the Society for Investigative Dermatology urge generous support for a number of other NIH institutes which support skin disease research.

Because of the substantial increase in the prevalence of skin cancer and in particular malignant melanoma, and because our superb dermatology intramural research program is in the National Cancer Institute, we have a major interest in continuing strong support for this very important institute.

We believe that adequate funding for the National Institute of Allergy and Infectious Diseases is essential, not only because of its pivotal role in

STATEMENT OF DR. PEYTON WEARY

Mr. Chairman, I am Peyton E. Weary, M.D., Professor and Chairman of the Department of Dermatology at the University of Virginia School of Medicine and Washington Representative from the Council on Governmental Liaison of the American Academy of Dermatology. I am also a past Vice-President of the Society for Investigative Dermatology. I am presenting this testimony on behalf of the American Academy of Dermatology, whose membership of over 6,500 represents the majority of American dermatologists, and on behalf of The Society of Investigative Dermatology, the representative organization for the dermatologic biomedical research community.

Once again, I am pleased to report that there are many exciting developments in skin disease research, much of which is supported by funds you have appropriated. At this very moment the 1989 Tricontinential Meeting of the European Society for Dermatologic Research, the Japanese Society for Investigative Dermatology and our own Society for Investigative Dermatology is about to begin. A five day joint meeting will be held in this city at which many important scientific papers will be presented. As an indication of the intense interest in skin disease research, I can tell you that a record high number of 933 different presentations of scientific observations will be made this year at this meeting. The level of sophistication of the research is indeed impressive and much of this work is at the frontiers of molecular and cellular biology and immunobiology.

In the past you have heard testimony from representatives of the National Congenital Port Wine Stain Foundation. I am pleased to report to you that there is now a very safe and effective treatment for the skin lesions of many of these individuals using a special type of laser called a Tunable Dye Laser. I have appended to this testimony a reprint from the article which appeared in the New England Journal of Medicine which outlines this new treatment. Here we have a good example of how basic research such as that supported by your Committee and the Congress can be translated into improved patient care.

Mr. Chairman, we are most appreciative of the substantial add-on of $3.1 million dollars last year to the National Institute of Arthritis and Musculoskeletal and Skin Diseases (NIAMS), which the Congress granted.

AIDS research, but because of the need to support research in other viral diseases and many troublesome bacterial and fungal infections as well.

We believe that the graying of America portends a major shift in emphasis to more research in diseases affecting the elderly, and we support increased initiatives within the National Institute on Aging for skin problems of the elderly.

The skin is the major interface of the body with the environment and many environmental insults are first perceived because of their effects upon the skin. The National Institute of Environmental Health Sciences must be well supported to fulfill its important mission, particularly at this time when our fragile environment is threatened in so many ways.

We are particularly concerned this year about The National Institute for Occupational Safety and Health (NIOSH) which, while not an NIH institute, does support important research in occupational disease and in particular occupational skin disease. We have a major interest in occupational disease since a large percent of all occupational illness is skin disease. Our American Academy of Dermatology has developed a strong working relationship with NIOSH as demonstrated in an appended report (Appendix B). We are shocked that the Presidents' budget calls for a reduction in support for this institute from 70 million dollars for 1989 to 45 million dollars for 1990. The impact of such a cut would be devastating to this institute particularly since it has never been well supported in the past. We believe the President's proposed budget for NIOSH is a good example of the old adage penny wise - pound foolish, since the dollar loss of productivity of American industry resulting from occupational disease far exceeds any savings which might accrue from such a reduction. We urge that the Presidents' budget for this institute be rejected soundly, and that rather than a cut, a substantial increase be granted by the Congress.

Thank you and your Committee once again for your continuing devotion to research and for the opportunity of making this presentation.

Senator **Hatfield**. Thank you very much. You speak about the Institute as the National Center for Disease Control?

Dr. **Weary**. Yes, sir.

Senator **Hatfield**. Well, you again represent a very important part of our needs. I am very proud of an annual witness that comes back clear from the State of Oregon to testify on behalf of your budget. In the Advocate and Citizen's Group, Will Locktell, who comes from Portland on psoriasis.

Dr. **Weary**. Yes; and we are also very appreciative of your support for epidermolysis bullosa [EB], Senator. We know you are interested in——

Senator **Hatfield**. And EB. I was going to say Arlene Pessar and her son——

Dr. **Weary**. Yes.

Senator **Hatfield** [continuing]. Eric. Very, very important areas of great needs of help. Thank you very much, Doctor.

Dr. **Weary**. Thank you.

STATEMENT OF BARBARA MATIA

Senator **Hatfield**. Ms. Barbara Matia from Paradise Valley in Arizona.

We are happy to have you here this morning. You may proceed to highlight your testimony.

Ms. **Matia**. Mr. Chairman, Senators, and staff, for those of you who have not heard me testify in the past I believe it is important for you to know that I was completely bedridden 11 years ago with rheumatoid arthritis.

I was treated by Dr. Thomas McPherson Brown with oral and intravenous antibiotics over a long period of time. After getting through the period which this treatment causes you to feel worse, I improved each year, watching my blood tests go to an initial rheumatoid factor of over 10,000 to a zero reading after 5 years. As you can tell by looking at me today, I am totally functional and living a healthy normal life.

Dr. Brown and Dr. Homer Swift, who had been referred to as the father of modern rheumatology, first reported the isolation of a microplasma organism, then referred to as the pleuropneumonia-like organism or PPLO, in the March 24, 1939, issue of Science magazine. Both the New York Times and the New York Post carried articles on this achievement with headlines which read as follows, "Rheumatism Germ Found, Say Rockefeller Doctors, and Rheumatic Fever Cause Clues Are Found by Science."

That discovery occurred 50 years ago last month. Dr. Brown persisted in the direction of the infectious theory for arthritis for 50 years. Monday, April 17, 1989, he died. The gift he has left to the world is that there is real hope for the arthritics today. He was way ahead of his time with his theory that rheumatoid arthritis is a long-term acute illness rather than a chronic illness, and if treated properly with antibiotics over a long period of time, it is potentially curable.

Because of my experience with this disease and that of thousands of other patients which have been successfully treated by Dr. Brown, I know when a clinical trial is completed on the antibiotic treatment program and when the research is finally completed as to the cause of the disease, it will be established that Dr. Brown was right both to the cause and the treatment of rheumatoid arthritis.

According to the National Institutes of Health, there are over 100 different forms of arthritis, all needing specific research in various scientific disciplines such as genetics, immunology, and all needing separate clinical trials to test proper dosages of medicine found to be effective against one or more of those forms.

This is going to be an endless task when you consider that the NIAMSD is the third lowest Institute in funding at the National Institutes of Health and has the lowest grant payline of all the Institutes.

PREPARED STATEMENT

If you could devote substantial additional dollars to solving the arthritis mystery, this staggering annual economic loss would begin to diminish and the economic gain from such a result would more than pay for the investment. I urge you to seriously consider increasing the NIAMSD appropriation to $200 million for the year 1990. This money would have a significant positive impact on balancing future budgets.

[The statement follows:]

STATEMENT OF BARBARA MATIA

I AM BARBARA MATIA OF SCOTTSDALE, ARIZONA. I APPRECIATE THE OPPORTUNITY TO TESTIFY BEFORE YOU FOR THE THIRD TIME. FOR THOSE OF YOU WHO HAVE NOT HEARD ME TESTIFY IN THE PAST, I BELIEVE THAT IT IS IMPORTANT FOR YOU TO KNOW THAT I WAS COMPLETELY BEDRIDDEN ELEVEN YEARS AGO WITH RHEUMATOID ARTHRITIS. I WAS TREATED BY DR. THOMAS MCPHERSON BROWN WITH ORAL AND INTRAVENOUS ANTIBIOTICS OVER A LONG PERIOD OF TIME. AFTER GETTING THROUGH THE PERIOD DURING WHICH THIS TREATMENT CAUSES YOU TO FEEL WORSE, I IMPROVED EACH YEAR, WATCHING MY BLOOD TESTS GO FROM AN INITIAL RHEUMATOID FACTOR OF 10,000 TO A ZERO READING AFTER FIVE YEARS. AS YOU CAN TELL BY LOOKING AT ME TODAY, I AM TOTALLY FUNCTIONAL AND AM LIVING A NORMAL HEALTHY LIFE.

DR. BROWN AND DR. HOMER SWIFT, WHO HAS BEEN REFERRED TO AS THE FATHER OF MODERN RHEUMATOLOGY, FIRST REPORTED THE ISOLATION OF A MYCOPLASMA ORGANISM (THEN REFERRED TO AS A PLEUROPNEUMONIA-LIKE ORGANISM OR PPLO) IN THE MARCH 24, 1939 ISSUE OF SCIENCE MAGAZINE. BOTH THE NEW YORK TIMES AND THE NEW YORK POST CARRIED ARTICLES ON THIS ACHIEVEMENT WITH HEADLINES WHICH READ AS FOLLOWS: "RHEUMATISM GERM FOUND, SAY ROCKEFELLER DOCTORS;" AND "RHEUMATIC FEVER CAUSE CLUES ARE FOUND BY SCIENCE." THAT DISCOVERY OCCURRED FIFTY YEARS AGO LAST MONTH. DR. BROWN PERSISTED IN THE DIRECTION OF THE INFECTIOUS THEORY OF ARTHRITIS FOR FIFTY YEARS. LAST MONDAY, APRIL 17, 1989, . . . HE DIED. THE GIFT HE LEFT TO THE WORLD IS THAT THERE IS REAL HOPE FOR THE ARTHRITICS TODAY. HE WAS WAY AHEAD OF HIS TIME WITH HIS THEORY, THAT RHEUMATOID ARTHRITIS IS A LONG-TERM ACUTE ILLNESS RATHER THAN A CHRONIC ILLNESS, AND THAT IF TREATED

PROPERLY WITH ANTIBIOTICS OVER A LONG PERIOD OF TIME IT IS POTENTIALLY CURABLE.

BECAUSE OF MY EXPERIENCE WITH THIS DISEASE AND THAT OF THOUSANDS OF OTHER PATIENTS WHICH DR. BROWN HAS SUCCESSFULLY TREATED, I KNOW THAT WHEN A CLINICAL TRIAL IS COMPLETED ON THE ANTIBIOTIC TREATMENT PROGRAM AND WHEN THE RESEARCH IS FINALLY COMPLETED ON THE CAUSE OF THE DISEASE, IT WILL BE ESTABLISHED THAT DR. BROWN WAS RIGHT BOTH AS TO THE CAUSE AND THE TREATMENT OF RHEUMATOID ARTHRITIS.

ACCORDING TO THE NATIONAL INSTITUTES OF HEALTH, THERE ARE OVER ONE HUNDRED DIFFERENT FORMS OF ARTHRITIS, ALL NEEDING SPECIFIC RESEARCH IN THE VARIOUS SCIENTIFIC DISCIPLINES SUCH AS GENETICS AND IMMUNOLOGY, AND ALL NEEDING SEPARATE CLINICAL TRIALS TO TEST PROPER DOSAGES OF MEDICINES FOUND TO BE EFFECTIVE AGAINST ONE OR MORE OF THOSE FORMS. THIS IS GOING TO BE AN ENDLESS TASK WHEN YOU CONSIDER THAT THE NIAMSD IS THE THIRD LOWEST INSTITUTE AT THE NIH IN FUNDING AND HAS THE LOWEST GRANT PAYLINE OF ALL OF THE INSTITUTES AND THAT THE AWARD RATE FOR 1989 APPROPRIATIONS FOR THE NIAMSD IS ONLY 27% WHERE THE OTHER INSTITUTES HAVE AWARD RATES OF 29%.

WHEN YOU SAY YOU HAVE ARTHRITIS, PEOPLE DO NOT ASSOCIATE WITH IT THE TRAGEDY WHICH THEY ASSOCIATE WITH CANCER OR HEART DISEASE. ARTHRITIS IS NOT GENERALLY A KILLER. BUT THERE IS A TRAGEDY IN THE IMMEASURABLE SUFFERING WHICH ARTHRITICS ENDURE. AND ARTHRITIS HAS AN ADDITIONAL, ALMOST IRONIC, TRAGEDY ASSOCIATED WITH IT. BECAUSE ARTHRITIS IS NOT A KILLER, THE ECONOMIC LOSS TO AMERICA FROM THE REDUCED PRODUCTIVITY AND LOST EARNINGS, WHICH HAS

BEEN ESTIMATED IN THE TENS OF BILLIONS OF DOLLARS ANNUALLY, AND THE ECONOMIC BURDEN OF LONG-TERM MEDICAL AND CUSTODIAL CARE WHICH OFTEN BECOMES NECESSARY, IS A REAL AMERICAN TRAGEDY.

IF WE WOULD DEVOTE SUBSTANTIAL ADDITIONAL DOLLARS TO SOLVING THE ARTHRITIS MYSTERY, THIS STAGGERING ANNUAL ECONOMIC LOSS WOULD BEGIN TO DIMINISH AND THE ECONOMIC GAIN FROM SUCH A RESULT WOULD MORE THAN PAY THE INVESTMENT.

I URGE YOU TO SERIOUSLY CONSIDER INCREASING THE NIAMS APPROPRIATION TO TWO HUNDRED MILLION DOLLARS FOR FISCAL YEAR 1990. THIS MONEY WILL HAVE A SIGNIFICANT POSITIVE IMPACT ON BALANCING FUTURE BUDGETS.

Senator HATFIELD. Ms. Matia, you are a familiar figure here and we are so delighted to see you in your current status, the result of the investment of dollars in research. I really feel that you are the inspiration that creates the kinds of support that there is in this committee. We just appreciate your testimony very much.

Ms. MATIA. Thank you. I would like to add that there is $134,000 presently being funded on microplasma research, out of $161 million. I think that it is important, if you go back for 50 years and see how much money has been spent on microplasma research for rheumatoid arthritis, and I think to the low funding of this Institute, this is part of the reason why this clinical trial has not occurred and that they have not found the breakthrough for rheumatoid arthritis—is due to lack of funding.

I know Dr. Brown had research grant after research grant turned down due to lack of funding. So, whatever we could do to increase that would be gratefully appreciated.

Senator HATFIELD. As you know, we do not fund individual grants but leave that general responsibility to the Institute.

Ms. MATIA. And I respect that very much.

Senator HATFIELD. But if we keep the levels high, then there is more likelihood of getting the individual grants.

Ms. MATIA. Right. Thank you.

Senator HATFIELD. Thank you very much, Ms. Matia.

STATEMENT OF HERBERT SANDVIK, CHAIRMAN, GOVERNMENT AFFAIRS COMMITTEE, ARTHRITIS FOUNDATION

Senator HATFIELD. I would like to invite now Mr. Herbert Sandvik, chairman of the Governmental Affairs Committee of the Arthritis Foundation.

Mr. **Sandvik**. Sir, I have a sore throat and a cold from our hot weather in Phoenix.

Senator **Hatfield**. Mr. Sandvik, we appreciate your presence and also the foundation you represent.

It is now my honor to turn the hearing over to our ranking Republican member of this subcommittee—I started to say "Doctor"—Senator Arlen Specter. I have been dealing with so many doctors here today, Senator, that I almost bestowed that marvelous title on you.

Senator Specter [presiding]. Thank you very much, Mr. Chairman. That is reminiscent of an occasion where during a Warren Commission hearing on the day we examined the autopsy surgeons, Chief Justice Warren met a series of doctors, said, "Hello Doctor" to Dr. Humes, "Hello Doctor" to Dr. Bosell, "Hello Doctor" to Dr. Fink. Then one of the Commission staff members walked up, maybe he had not seen much of, and he said, "Hello Doctor." [Laughter.]

Senator **Specter**. Welcome. Is it Mr. Sandvik or Dr. Sandvik.

Mr. **Sandvik**. Herb Sandvik. No; not doctor.

Senator **Specter**. All right.

Mr. **Sandvik**. I am retired.

Senator **Specter**. I appreciate your joining us and we look forward to your testimony.

Mr. **Sandvik**. Good morning. My name is Herb Sandvik and I am a volunteer and chairman of the Governmental Affairs Committee of the Arthritis Foundation.

I was going to tell you some figures, et cetera, but there has been so many figures on the arthritis people involved, and things, but I would like to ask that my written statement be placed in the record.

Senator **Specter**. It will be made a part of the record, without objection, Mr. Sandvik.

Mr. **Sandvik**. Thank you.

Senator **Specter**. You may proceed.

Mr. **Sandvik**. I would like to take a few moments and tell you how far we have come in the past few years.

I am an excellent example of what research dollars has accomplished over the past years. Forty years ago, when I was 20 years old, I came down with ankylosis spondylitis, a form of arthritis that attacks the spine of mostly young men and women.

At that time, when I was 20, I was 6 feet 1½ inches tall. I am now about 5 feet 6 inches or 5 feet 7 inches, depending on the humidity of the air. I weighed about 205 pounds and I played semipro hockey. So, you can see, I have dwindled down somewhat.

The arthritis became worse and worse, and the pain grew so intense, that I had to sleep, or try to sleep, in a chair upright. I could not lay on my back anymore because the pain was so great.

This lasted for about 12 to 13 years. Then my knees and hips started to swell and the pain was so great that I could hardly walk. I tried canes, et cetera, but still had trouble walking. Then my shoulders. I could not lift my arm, the pain was so intense. So, that got rid of the cane and everything else.

Then my jaw was next. I could only open my jaw enough to put a straw or mashed foods in. And you must remember, in those days about all there was left for a helpless pain was aspirin. Then I received an ulcer from the aspirin by taking so many.

Things became so bad that in desperation I went to Mexico. Quack treatments. I was to the point that I could not walk, sleep, or anything, because of the intense pain. I went to Mexico, back and forth for 2½ years. I had the moon face and all. Overdoses of cortisone. I did not know that at that time.

I might add that I speak against going to Mexico now. I appeared before a congressional hearing chaired by Claude Pepper on quackery and told them my experiences in Mexico where I almost died from the overdoses of cortisone.

The cortisone was starting to take a toll on my body, and I was very lucky then. A young doctor from Mayo Clinic in Rochester, MN, moved to Fargo where I lived. Some doctor friends of mine sent me to him. He was Dr. Jim Carpenter, who was a rheumatologist. We did not have one before that.

Right away he could see what was beginning to happen to me. He put me in a hospital for 1½ months and slowly weaned me off the cortisone. He put me on some anti-inflammatory drugs. This reduced the pain and swelling in my joints. When the pain and swelling went down, then I was able to get mobility back in my hands through exercise.

I soon became a very active person. I then had artificial knees put in. Also had an artificial hip. Then I really became active again. I even played golf. Now I have an 18 handicap. Not bad for someone that might have been in a wheelchair or bedridden, and have been a burden on society.

But for you people that had the foresight to appropriate funds for medical research in arthritis, that is where I would have been and many thousands more like me.

PREPARED STATEMENT

It does not stop here. The NIAMS needs more funding for research dollars, and maybe with all of us working together we can find a cause and cure for arthritis. Would it not be great for some young man or woman about 20 years old who comes down with ankylosis spondylitis and we were able to tell them we had a cure and they would not have to go through the life of pure hell and pain and not be bent over like me?

Again, thanks to this committee for letting me tell my story, and all of the rest of the 31 million like me. Without your support, I am sure I would not be here today.

Thank you very much.

[The statement follows:]

STATEMENT OF HERBERT SANDVIK

Mr. Chairman, distinguished Members of the Subcommittee, my name is Herbert Sandvik, Chairman of the Government Affairs Committee for the Arthritis Foundation. I appreciate the opportunity to testify before you today and speak on behalf of the 70 chapters of the Arthritis Foundation across the country. We are testifying on behalf of the National Institute of Arthritis and Musculoskeletal and Skin Diseases (NIAMS) which was established as a separate institute 5 years ago.

Approximately 37 million, or 1 in 7, Americans suffer from arthritis or related disorders. In fact, arthritis and other musculoskeletal pain account for the largest proportion of new pain symptoms reported to physicians. It has been estimated that arthritis and related disorders cost the Nation an estimated $31 billion annually in medical expenditures and associated economic costs as compared to the $168 million spent on research for these disorders. Clearly this is a disease with tremendous economic costs which has not assumed a proportionate burden of the medical research pie.

In taking a look back at the past five years, it is necessary to pause and thank you for the support of the Congress in funding the research programs supported by the NIAMS. The research and training supported by NIAMSD has had a profound effect on persons diagnosed with arthritis and has provided much comfort and brighter futures for many. Mr. Chairman, I would be remiss if I did not thank the Congress for their efforts on behalf of the 37 million persons afflicted with this disease. We are well aware of your support of these programs and want to publically recognize this Subcommittee's contribution.

The Arthritis Foundation supports the recommendation of the Ad Hoc Group for Medical Research in requesting that the National Institutes of Health (NIH) be provided about $890 million above the 1990 President's Budget Request. It will take almost $8 billion to maintain current programs at NIH at their operating level -- the 1990 Budget Request is about $500 million short of this level.

NIAMS supports a variety of research initiatives through its intramural and extramural programs. The NIAMS budget for 1990 is $168 million, an increase of almost $8 million. However, in constant dollars, the increase in funding for NIAMS from 1987 to 1989 is only $3 million. Under the 1990 request, the NIAMS will

* fund 131 competing grants; a decrease of 48 grants from 1987;
* fund grants with a priority score of 140 -- 10 points lower than the overall NIH priority score, 7 points lower than scores in 1987, and, 20 to 40 points lower than other NIH institutes of comparable size;
* provide an award rate for NIAMS of 17%, as compared to the NIH average of 26%;
* necessitate downward negotiations of all competing grants by 10%;
* maintain 26 centers but necessitate an 18% downward negotiation in funding; and,
* fund 54 career awards and 194 training awards, down by 7 and 48 awards respectively.

The Arthritis Foundation has been working with a coalition of 30 organizations to develop a proposal for increased funding for the NIAMS. In that regard, we urge you to fund the NIAMS at a level of $192 million, $24 million above the 1990 President's Budget Request. Funding at this level would allow the NIAMS to provide for the following.

* 251 competing grants, instead of a decrease of 54 grants as proposed in the 1990 Budget Request;
* fund competing grants at a payline of 170 which is in keeping with other NIH Institutes of the same size;
* provide for an award rate of 36% for grants, instead of the 17% proposed in the 1990 Budget Request;
* drop downward negotiations to 4%, instead of the 10% proposed in the 1990 Budget Request;

* maintain the present 26 Centers, but decrease the downward negotiations from 18% to 6%; and

* restore the number of trainees to the 1987 level.

As mentioned, in the 1990 President's Budget Request 26 centers will be supported; however, funding has decreased by $271,000 and a downward negotiation of 18% is expected. This follows a 15% reduction in 1988 and a 16.3% reduction in 1989. We strongly support the Centers which are designed to

* support basic and clinical research programs which are vital in discovering new scientific information essential for the control of the over 100 forms of this disease;

* provide a mechanism for the rapid and effective application of research findings into clinical practice; and,

* provide educational programs for health care professionals.

We urge you to consider fully funding the existing Centers.

We are also concerned about the stability of the research training programs and the implications that the recent decreases, both in numbers and dollars, will have on our long term investment in research. A decrease of 48 awards within NIAMS does not speak to what we believe must be a long term commitment -- paying today and reaping the benefits in the next decade. Since it takes on the average 8 to 10 years of post-baccalaureate education to train a research scientist, and because many of our research initiatives are actually carried our by trainees, we are compromising the future development of our best initiatives. We urge this Subcommittee to closely examine the needs of training to meet the demands of our research efforts and request that you consider providing $191.9 million to NIAMS to meet its needs.

Many exciting opportunities await us. One area of promising arthritis research focus is immunology. In rheumatoid arthritis, antibodies, which are suppose to protect the body by attacking foreign substances, attack the body itself and destroy bone joints. Researchers are attempting to ascertain why this occurs by measuring the specific level of antibodies in different types of arthritis, age, sex and racial factors which may contribute to antibody detection. By answering these questions, we will be able to better define the type of treatment for persons afflicted with this disease.

On another front, scientists are investigating through molecular biology whether or not arthritis may have a genetic link. This may hold some clue as to the cause of arthritis and the role of certain genetic markers in the early detection of arthritis.

We have come far in a short period of time. I believe that this is a result of our combined efforts. The NIAMS spent $71 million on arthritis research in 1988, the Arthritis Foundation spent $8 million; since its inception, the Arthritis Foundation has spent $53 million on its research efforts. If every one continues to do their share, we will eventually have the battle won.

In conclusion, the Arthritis Foundation, along with the NIAMS Coalition asks that you support $191.8 million in funding for the Institute in FY 1990. We believe that this appropriation reflects our research needs based upon the best scientific judgement and will move NIAMS closer to parity with comparable Institutes.

Thank you for your attention to this matter. This concludes my formal testimony and I will be happy to answer any questions that you may have regarding my statement.

Senator **Specter**. Thank you very much, Mr. Sandvik. You have a very important and impressive story to tell, and we appreciate your coming forward and doing so.

STATEMENT OF POLLY MURRAY, LYME DISEASE AWARENESS TASK FORCE

Senator **Specter**. I would like now to call on Ms. Polly Murray, Lyme Disease Awareness Task Force.

Ms. **Murray**. Thank you, Mr. Specter. My name is Polly Murray. I have lived in Lyme, CT, since 1959. I am speaking in support of the Comprehensive Lyme Disease Act of 1989, S. 223.

As someone who has dealt with Lyme disease on a personal, family, and community basis for over 20 years, I urge the passage of this bill. After years of mysterious symptoms, several hospitalizations, consultations with approximately 30 doctors, and a frustrating search for a diagnosis, I reported in the fall of 1975 to the State health department and to Dr. Allen Steere at Yale University my observations about a chronic debilitating multisystem illness affecting our family as well as others in Lyme and neighboring towns.

The recurrent rashes, fatigue, neurological, and arthritic symptoms were puzzling. The expanding target-like rash was something unusual. The bulging knee and other joint swellings were incapacitating. Three members of the family had been on crutches. Several family pets had been affected as well.

This disease can destroy the normal functioning of a family.

Early diagnosis of this illness is extremely important because it becomes more difficult to treat the longer that it goes undiagnosed. I hear of people from every area of our country who have not been properly diagnosed. Increasingly, families, pets, cows, and horses are afflicted.

Programs should be initiated for the education of doctors about diagnosis and treatment of this complicated illness. Perhaps within every State there could be a designated researcher on Lyme disease in each specialty who would gather information and become an advisor to other professionals in their particular field.

All veterinarians should be aware of the disease.

In some instances of Lyme disease cases that were untreated or unsuccessfully treated in early years are now showing later stage problems. In some there is reinfection. Add these to the new infections every year, and the numbers of sufferers is rising rapidly. Since 1982 the CDC has reported 14,000 cases. Last year New York cases rose threefold from 1987.

Many victims have continuing health problems. In some the long-term psychological and physical debilitation has been severe, including problems with the infants of those infected during pregnancy, dementia, behavior and personality problems, sensory disturbances, paralysis, and a small number of deaths.

At this point it is naive to think that all of the clinical manifestations are known. There is much more to be described, and long-term followup studies in a highly endemic area must be funded in order to understand these chronic symptoms.

PREPARED STATEMENT

Education. prevention, tick control, better diagnostic tests, increased reporting by physicians, improved treatments, and the development of a vaccine are a top priority in fighting this disease.

Thank you.

[The statement follows:]

STATEMENT OF POLLY MURRAY

My name is Polly Murray and I am from Lyme, Connecticut, where I have lived since 1959. I am speaking in support of the "Comprehensive Lyme Disease Act of 1989." (H. R. 979, S.223) and of "Lyme Disease Awareness Week." I am a member of the Lyme Disease Awareness Task Force, The Arthritis Foundation, Connecticut Chapter.

It is from the perspective of someone who has dealt with Lyme Disease on a personal, family, and community basis for over twenty years that I urge the passage of this bill. In October of 1975, as a concerned mother of four children, after numerous hospitalizations and many frustrating years searching for a diagnosis, and having done some research on my own, I reported to the State Health Department my observations about a chronic, debilitating, and frightening multisystem illness that had affected our family as well as others in Lyme and neighboring towns. I seemed to be dealing with something that was on the one hand very real in terms of symptoms, but on the other hand didn't exist in the medical literature. The recurrent rashes, fatigue, neurological, and arthritic symptoms were puzzling. The expanding target-like rash was something unusual. The bulging knee and other joint swellings were incapacitating. Three members of the family had been on crutches. Several family pets had been affected as well. This disease can destroy the normal functioning of a family. In November 1975, I informed Dr. Allen Steere at Yale University of many more suspected cases. This illness was at first referred to as Lyme Arthritis, but later changed to Lyme Disease as its complicated clinical presentation was documented.

During a period of many years, members of our family were seen by approximately thirty doctors from different specialties with symptoms now known to be caused by Lyme Disease. The problem had increased as a result of a tremendous rise in the population of deer and a subsequent increase in the number of ticks infesting our geographic area.

It is now known that prompt, early diagnosis of this illness is extremely important, because it becomes more difficult to treat the longer it goes undiagnosed. On a daily basis, I hear of people from every area of our country who have not been properly diagnosed. Increasingly, entire families and their pets are afflicted. Cows and horses are also infected. I suggest that programs be initiated for the education of all practicing doctors in every specialty about diagnosing and treating this complicated illness. In the ideal situation, within every state, there would be a designated researcher on Lyme Disease in each specialty who would gather information and become an advisor to other professionals in their particular field. All veterinarians should be aware of the disease. General public awareness must catch up with the current research findings; however it does not make sense to have a fully knowledgeable patient if the doctors that they go to are not able to recognize and treat the disease in all of its manifestations and stages. Sadly, patients often are seen by numerous physicians in their search for diagnosis and effective treatment. In some instances, Lyme Disease cases that were untreated or unsuccessfully treated in early years are now showing later stage problems; in some there is reinfection. Add these to the new infections every year, and the numbers of sufferers in endemic areas is rising rapidly. Everywhere I turn, people tell me of the problems they are having with the deer, ticks, and resultant illness. Many victims had been healthy people before the onset of Lyme Disease, however, since infection, they have had constant health problems. In some, the long term psychological and physical debilitation has been severe, including problems with the infants of those infected during pregnancy, dementia, behavior and personality problems, and even sensory disturbances, paralysis, and a small number of deaths. Follow up studies must be funded in order to see if these chronic symptoms are due to the continuing presence of the Lyme Disease bacteria, or to an altered immune system resulting from the infection. Appropriate treatment should then be determined.

Education, prevention, tick control, better diagnostic tests, increased reporting by physicians, improved treatments, and the development of a vaccine all are of top priority in fighting this disease. I do not feel that all of the clinical manifestations of the disease have yet been described. I have lived to see many of the hunches that I had in the 1970s become the reality of the 1980s.

The health and stability of ever increasing numbers of families are being affected by this devastating illness. I cannot emphasize enough the urgency for the Federal Government of the United States to enact this legistlation for Lyme Disease as the responsible approach to this major health problem which has the potential of endangering virtually any citizen of our country. This disease is not only a national problem but a global problem as well, and our country should take the initiative in promptly dealing with the many, as yet, unanswered questions associated with it. Thank you.

Senator SPECTER. Thank you very much for your testimony, Ms. Murray. We very much appreciate your coming in.

STATEMENT OF DR. PAUL R. CHENEY, NALLE CLINIC SOUTH, NATIONAL CHRONIC FATIGUE SYNDROME ASSOCIATION

ACCOMPANIED BY R. BARRY SLEIGHT, EXECUTIVE DIRECTOR, CHRONIC FATIGUE SYNDROME INFORMATION INSTITUTE

Senator SPECTER. I would like now to call on Dr. Paul Cheney, Nalle Clinic South, Charlotte, NC, with the National Chronic Fatigue Syndrome Association.

Dr. CHENEY. Thank you, Senator. I am appearing with Barry Sleight, a volunteer with the Chronic Fatigue Syndrome Information Institute on my right.

I am presenting this testimony as a physician engaged in clinical research for the past 5 years in over 1,000 patients with a chronic fatigue and immune dysfunction syndrome known as DFIDS, also called chronic fatigue syndrome.

Despite the numerous and often nonspecific complaints of patients with this syndrome, a pattern of illness and the most important elements are becoming ever more keenly appreciated. An abrupt loss of health and vitality in a previously healthy adult, a prolonged course without clear-cut resolution, and the unusual loss of cognitive skills is seen almost without exception in what is termed the classic case. There are patterns of objective abnormalities seen primarily in the immune system and in the central nervous system.

Numerous reports, much of it anecdotal and preliminary, suggest that the chronic fatigue syndrome may be on the rise. A recent San Francisco Department of Health survey showed that physicians, a majority of physicians in that city felt that this syndrome was increasing.

Another nonscientific survey of patients in CFIDS support groups from 35 States shows an exponential rise in cases produced each year since the late 1970's. This curious temporal and case production relationship with the AIDS epidemic has prompted some researchers to project DFIDS as an AIDS epiphenomenon. Indeed, the new human herpes virus, HHV-6, may be among the most important cofactors shared both by AIDS and CFIDS.

If we take a recent CDC estimate of 7 cases per 1,000, then the economic impact could exceed $30 or $50 billion per year. If this figure is not frightening enough, then consider that most of my colleagues in San Francisco think that this disease is rising and we do not even know what it is.

If there was ever a grassroots disease, this is it. What clues there are to this disorder lie presently in listening carefully to patients. I would ask that you please read from the several patient case studies attached to my testimony.

Senator SPECTER. Your full testimony and the case studies will be included in the record, Dr. Cheney.

Dr. CHENEY. The CFIDS problem will not go away. It is real. It seems to be on the increase and, if so, its relationship to the AIDS epidemic will need to be investigated with great urgency. A problem such as this, which has consistently grown in the face of enormous skepticism within our medical establishment, is most deserving of your attention and serious consideration. The other shoe will inevitably drop on this problem. Please be certain that it will not drop unheeded by this committee.

PREPARED STATEMENT

I endorse the recommendations for specific funding levels put forth by the federations of CFIDS support groups which includes the CFIDS Society of Portland, OR, one in Kansas City, and in Charlotte.

Those recommendations include $15 million to the Centers for Disease Control for expanded surveillance on network, and $10 million for expanded extramural research supported by the NIAID.

Thank you.

Senator SPECTER. Thank you very much, Dr. Cheney. We will insert in the record immediately prior to your testimony a letter from Congressman Bill Hefner who wanted to be present to introduce you, but his schedule prevented his being here. He has a strong testimonial to your expertise and your qualifications as a physician researcher. So, we thank you very much.

Dr. CHENEY. Thank you.

[The statement follows:]

LETTER FROM BILL HEFNER, U.S. REPRESENTATIVE FROM NORTH CAROLINA

May 4, 1989

Senator Arlen Specter
Acting Chairman
Appropriations Subcommittee On
Labor, HHS, & Education
186 Dirksen
Washington, DC 20510

Dear Senator Specter:

I regret very much that my schedule prevents my being present today to personally introduce to the Subcommittee Dr. Paul Cheney, a resident and practicing physician from the Eighth District of North Carolina.

Dr. Cheney is an eminent physician and researcher who has considerable experience in the investigation and treatment of a previously little known and mysterious disease which is debilitating increasing numbers of individuals who suffer from Chronic Fatigue Syndrome.

He has been involved in clinical research in this disease for the past 5 years, both in Charlotte, North Carolina, and in Lake Tahoe, Nevada. He has authored or co-authored articles on this topic appearing in medical journals and presented papers before national conferences.

Dr. Cheney is a well trained scientist whose first love was scientific medical research. He received his undergraduate degree in science from Eckerd College in Florida, a degree of Doctor of Philosophy in Atomic Physics from Duke University, and a degree of Doctor of Medicine from Emory University.

In addition to his clinical experience as a private practicing physician and Chief of Staff of a U. S. Air Force Hospital during his military service, he has served as Research Associate in the Division of Immunology at the Centers for Disease Control. His training and clinical background make him an extremely qualified witness to enlighthen the Congress on this debilitating illness.

I am pleased to present to you Dr. Paul Cheney.

Sincerely yours,

Bill

BILL HEFNER
Member of Congress

STATEMENT OF DR. PAUL R. CHENEY

Mr. Chairman, I am presenting this testimony as a physician engaged in clinical research for the past five years on over 1,000 patients with the Chronic Fatigue and Immune Dysfunction Syndrome (CFIDS) also known as the Chronic Fatigue Syndrome (CFS). I have been witness to the epidemic form of this disorder on the north shore of Lake Tahoe in 1985 and more recently to the apparently sporadic forms of CFIDS in North Carolina and the Southeastern United States since 1987. I have authored and co-authored several original articles on this disease in peer reviewed medical journals. I have spoken at several national conferences on this subject since 1986 and most recently to over 500 physicians and researchers assembled in San Francisco last month.

Despite almost five years of experience in the field and collaborative efforts with researchers in over twelve bio-medical institutions, both public and private, I am still unable to provide to you definite answers to the most fundamental questions:

(1) What is Chronic Fatigue Syndrome or CFIDS?
(2) What causes Chronic Fatigue Syndrome or CFIDS?
(3) Is there effective treatment beyond symptom relief?
(4) What is the current public health burden and what can we expect in the future?

Whereas no one really knows the answers to these very important questions there has been in recent years some observable movement on all four questions, almost all of it as a result of the congressional process of which I am today a participant. The most remarkable thing about Chronic Fatigue Syndrome is that the impetus for its recognition as a defined clinical entity has come primarily from patients. If there was ever a grass-roots disease, this is it. What clues there are to this disorder lie presently in listening carefully to these patients. There is no body of knowledge yet developed to truly describe these patients and no real specialists to provide you with insight. Most of those from the corridors of academia and government research offices have not listened carefully to more than a handful let alone the thousand or so it would take to begin to get a feel for this both monstrous and yet subtle disease. The advice of our greatest clinicians applies today as it did long ago: "Listen to the patient and they will tell you what is wrong". Please listen to those with Chronic Fatigue Syndrome, now called Chronic Fatigue and Immune Dysfunction Sydrome or CFIDS.

(Case studies attached)

Despite the numerous and often nonspecific complaints of patients with this sydrome, a pattern of illness and the most important elements are becoming evermore keenly appreciated. An abrupt loss of health and vitality in a previously healthy adult, a prolonged course without clear-cut resolution and the unusual loss of cognitive skills is seen almost without exception in what is termed the "classic case". While there is no single test which is always abnormal in patients with CFIDS and always normal in healthy controls, there are patterns of abnormalities seen primarily in the immune system and in the central nervous system.

Immune system dysfunction could account for every symptom seen in CFIDS including those of central nervous system origin. Unfortunatly, clinical and sub-clinical immune system dysfunction is likely to be common and generic with many potential causes. The study of CFIDS can therefore merge quickly into a continuum of ill-defined problems and nonspecific symptoms of immunologic disorder. The same of course could be said of many other well defined disorders including AIDS. We must therefore focus on the "classic" CFIDS patients because in these patients we are most likely to eventually find a common pathophysiology if not a common cause.

Of course it is possible, as it was with AIDS, to find a common cause in an as yet undetermined percentage of CFIDS patients. Such a common denominator, if it exists, would be critical to any assessment of the risks to the larger public health.

Numerous reports much of it anecdotal or preliminary suggest that the Chronic Fatigue Syndrome may be on the rise. A recent San Francisco Department of Health survey showed that 43% of primary care physicians in San Francisco were caring for at least one patient meeting the CDC criteria which requires that a significant and lengthy period of disability be demonstrated. Several physicians were each caring for several hundred of these patients. One physician not included in the survey and a former UCSF clinical professor of medicine was caring for 1100 patients. A majority of the randomly selected physicians felt that the syndrome was increasing.

Another non-scientific survey of patients in CFIDS support groups from 35 states shows an exponential rise in cases produced each year since the late 1970's. This curious temporal and case production relationship with the AIDS epidemic has prompted some researchers to project CFIDS as an AIDS epi-phenomenon. Indeed the new human herpes virus HHV-6 may be among the most important co-factors shared by both AIDS and CFIDS.

The CDC now receives 100 calls from patients and physicians each week. CFIDS related calls to the NIAID, an AIDS dominated institution in Bethesda, Md., are outnumbered only by AIDS related calls. Thousands of social security and private disability claims list CFIDS as the principal cause of disability. Many schools systems provide homebound instruction to children with this disorder. This disorder has already or will likely cost this country billions in lost productivity and health costs and ironically from its most productive segment, the young and middle aged adult. It could easily dwarf the economic effects of AIDS and sap the nation of its economic vitality.

The CFIDS phenomenon has boiled from the bottom up. From patients to primary care physicians and thence to the media and of course to the halls of congress. You shouldn't be surprised that confusion reigns in the rarefied domain of the Ivory Tower. A new element with old roots has entered the field. Threads of this problem weave their way back in time to similar but perhaps smaller problems cast away as unsolvable by the technology of the day. Today the generals charged with developing strategy do not know the enemy. They have not seen its face. They have trusted to their staff lieutenants who have never been in the trenches and who share the same bias.

The CFIDS problem will not go away. It is real. It seems to be on the increase and if so its relationship to the AIDS epidemic will need to be investigated with great urgency. A problem such as this which has consistently grown in the face of enormous skepticism within our medical establishment is most deserving of your attention and serious consideration. The other shoe will inevitably drop on this problem. Please be certain that it will not drop unheeded by this committee.

I endorse the recommendations for specific funding levels put forth by Mr. R. Barry Sleight of the Chronic Fatigue Immune Dysfunction Syndrome Association and that these be directed funds to each agency named by Mr. Sleight.

I would advise the Congress to require that the peer review panels charged with reviewing grant applications relating to CFIDS include only persons knowledgeable about this disorder.

I make a special plea to fund a small grants pilot project for CFIDS clinicians doing clinical research in communities apart from major medical centers. Just as in AIDS these physicians will be the future conduits to patients for information to and from our major research centers. Funding for legitimate research in this arena deserves special attention since most of the patients are for the moment found there.

CASE STUDIES-CFIDS

Case Study #1

32 yo occupational therapist (Minnesota)

After having a mono-like illness in Feb. 1985, I felt I never got back to feeling like myself. I tried to find out why and was told that mono should have been cured, the tests showed nothing wrong and that I was probably suffering from depression. Mental Health personnel felt they couldn't help me because my symptoms were so physical. In Nov. 1986 I became very ill with a number of infections. I have been on medical leave from my full time position in hopes of avoiding acquiring additional illnesses. It seems my immune system is depressed and I get a lot of illnesses. . . .

Case Study #2

42 yo computer operator (California)

I've always been very good with math, used to be a bookkeeper, a very good one. Now, I can't even balance my checkbook right. Driving is becoming difficult, to the point I don't drive unless absolutely necessary. Until last summer, I was very active with horses, now it's a chore to even walk to the barn. . . .I'm unable to remember what I'm doing in the middle of the simplest task at work--tasks I've been performing for three years.

Case Study #3

36 yo attorney (California)

During the first 3 months of my illness I was in bed most of the time, having no energy to do anything. I had chills, sweats, muscle aches in my upper back, racing pulse, and chronic fatigue. . . . .I am usually exhausted and unable to walk the first day or two of my period. Fatigue is overwhelming. A comprehensive exam showed no gynecological problems. . . .I am still unable to work due to fatigue. I get 10-12 hours of sleep each night. I've had dozens of other tests to rule out any other illnesses. The results were all negative.

Case Study #4

43 yo college professor (Ohio)

I was a healthy, type A person, successful, at the peak of my career. I became ill on September 28, 1985. I ended a week of teaching, flew to a meeting in St. Louis, Mo., and was sick in a motel the next day with what I thought was the flu. I never came out of it. In early December 1985 my physician's diagnosis was CEBV (now CFS). Not much improvement from 9/85 to the present. . .I can only work 3 days/week.

Case Study #5

35 yo fireman (Texas)

In Sept. 1984 I had a bad cold or a flu. Besides the usual stuffy nose and sore throat, I felt physically weak and extremely light-headed. The cold symptoms were gone after about eight days but the lightheadedness or drunk feeling is still with me--over two years later. I spent 17 months seeking help from various physicians and clinics before I was diagnosed as having CEBV (now CFS) . . .I am about to have to give up my career in the Fire Dept. because of this. . . And more importantly I have a six-year-old son that I would like to be a dad to. . . .

Case Study #6

31 yo waitress (California)

Symptoms wax and wane over time. As time goes on the attacks are less severe . . .I feel a lot more positive about things than I did last winter but I worry that my symptoms will worsen. Also I'm a little concerned about whether my mental faculties will return to normal as well. I have had trouble spelling when I write and I also leave out letters which I have never done before. Will this thing ever totally go away?

Case study #7

32 yo unemployed (Ohio)

I am hit with this 3 weeks out of 4. Whatever this illness is, it's winning. I don't feel like a person anymore, part of that is just because I'm so tired and stiff but the other part is the horrible depression which sets in when I feel this way. . . Symptoms include the following: bruising, exhaustion, joint pain, headaches, visual probelms, chest pains, constant bladder and kidney infections, cough--this just names a few. Naturally, I am in a deep depression but when you get this lousy it's hard to put a smile on your face and pretend nothing's wrong. Please help me--I can't take the feeling of hopelessness any longer!

Case Study #8

38 yo former graduate student (Texas)

Emotionally this takes a huge toll. The best way to express my feelings is to say that I feel that I have been robbed. My mental functions are diminished. I can't trust my senses. . . things don't smell, feel, taste, or sound right sometimes. I have no energy. I had just made a mid-life change and graduated from college. I have never been able to use that degree. I have been robbed of my sources of self esteem . . .looks, intellect, satisfying family life, earning power and not necessarily in that order. It took me nearly a year to get a handle on those feelings. . . . The CFS motto should be "Of all the things I've lost, I miss my mind the most!"

Case #9

48 yo nurse (Washington State)

. . .My doctor advised me to limit activities, rest and take a leave of absence from work. I tried to continue with some normal activities, becoming so tired at times I thought I would just die of being so tired. It was one year before I was able to return to work part-time. I have never again returned to my full energy level, but I have adjusted.

Case #10

52 yo disabled airline pilot (North Carolina)

I got sick suddenly with a flu-like illness while in a simulator training course two years ago in France. For months I could hardly get out of bed and I could not think at all. . . I don't seem to be able to process complex information correctly. I have improved but I cannot yet land the airplane in the simulator. . . it always crashes. My greatest wish is to get well and return to flying. My greatest fear is that I may never fly again.

STATEMENT OF DR. RONALD D. HUNT, NEW ENGLAND REGIONAL PRIMATE CENTER, HARVARD MEDICAL SCHOOL

Senator **Specter**. I would like to call Dr. Ronald Hunt, New England Regional Primate Center from Harvard Medical School. Your full statement will be made a part of the record, and you may proceed.

Dr. **Hunt**. I would just highlight a few points, Senator Specter.

I am pleased to be here representing the seven regional primate research centers in the United States, each one of which is hosted by a major university.

These centers, in addition to being research centers in their own rights, serve as regional resources—essentially national resources for the biomedical community at large and literally hundreds of grants from the National Institutes of Health, other governmental agencies, as well as research supported by private foundations, are dependent on the existence of the primate centers in that there are very few laboratories in this country capable of working with nonhuman primates.

At any given moment there are several hundred scientists from a multiplicity of institutions that are not a component of the host institution of the primate centers using these resources.

Research with primates touches upon almost everything that this committee hears about. Primates are being used in making important contributions to the understanding and treatment of heart disease, hypertension, malaria, ulcerative colitis, diabetes, vision, drug addiction, just to name a few.

More recently, the primate centers have addressed another national and international crisis, and that is AIDS. I need not elaborate on this epidemic caused by a virus which has already claimed so many lives and is estimated to affect many millions more.

I am very pleased to tell you, Senator Specter, that the primate centers program have developed an excellent nonhuman primate model with which to study AIDS, a model that should greatly speed both therapy and vaccination. In fact, as of this moment the only promising experimental evidence that a vaccine may be possible comes from research being done at the primate research centers.

In the two published reports on AIDS by the National Academy of Sciences, both reports urge increased support and expansion of the primate research centers to take advantage of these findings.

I would like to point out that in addition to undertaking these research missions, the primate centers have had to address another major task, which was not foreseen when the program was established by Congress in the 1960's. That is, establishing large breeding colonies to make primates available for research. Many species are now endangered and threatened and the only way we are going to have them to take advantage of their unique characteristics is to breed them ourselves.

As the difficulties in conducting primate research have increased, so have the costs. But the core support, the base support for the primate centers, has not increased. It has declined. The core support provides the infrastructure upon which all of this other research is dependent. That includes paying our utilities.

Last year the appropriation resulted in a 2.7-percent reduction. The year before, it was static. The current administration's budget would call for a 1.2-percent cut.

If we look at funding in 1980 as compared to 1989, taking into account the biomedical research and development price index, our funding is 20 percent lower in that 8-year period.

The recommended and approved funding for the Primate Centers Program, as approved by the NIH peer review system, is $35.5 million. The actual level, unless this committee acts otherwise, will be about $25.5 million. There is a very significant difference, and it is my plea to urge Congress to appropriate the additional $10 million in the proposed 1990 budget such that we can have a base core infrastructure budget that will be at a level that is recommended by peer review.

PREPARED STATEMENT

I would like to point out one other thing, that I will be back next year unless Congress takes some action. As you may be aware, Congress passed amendments to the Animal Welfare Act a year ago, and the Department of Agriculture has come up with recommended rules that the biomedical community will have to follow. Then, with their own figures, it is estimated that this will cost $1 billion for increased animal care efforts. Almost that approaching our total AIDS budget.

Thank you very much.

[The statement follows:]

STATEMENT OF DR. RONALD D. HUNT

I am Dr. Ronald D. Hunt, Professor of Comparative Pathology and Director of the New England Regional Primate Research Center at the Harvard Medical School. I am here today representing all seven of the NIH-sponsored Primate Research Centers, each located at a distinguished University in Louisiana, Wisconsin, Georgia, Oregon, Washington, California and Massachusetts.

I thank the Committee for the opportunity to appear before you. As you know, I have met with this Committee on a number of occasions and I appreciate the consideration and the positive responses that you have shown to the Primate Center Program over the years. Today I wish to make the Committee aware of a number of events and circumstances that tax the very ability of the Primate Research Centers from adequately carrying out their missions.

The Regional Primate Research Centers were established by the United States Congress in 1960, after three years of intensive study to determine the Nation's needs regarding nonhuman primates in biomedical and behavioral research. Congress made funds available to universities from 1960 through 1962 on a competitive basis for construction of the Centers and by 1965 all seven were complete and the research programs were in operation. Twenty-three years later, the Centers continue to operate by competitive core grants awarded by the Division of Research Resources of N.I.H. and individual awards to investigators from the categorical institutes.

Because of their unique characteristics, nonhuman primates are crucial for many medical research studies with animals; studies that must precede human research and application. Center breeding programs and research on the biology of primates have been critical to ensuring that primates remain available to scientists throughout our Nation. Now that so many species have become endangered or threatened with extinction or cannot be imported owing to exportation bans imposed by their native countries, the importance of the role of primate centers cannot be overemphasized.

The need to maintain large breeding groups, not planned for in initial construction of facilities has, however, taxed Center resources.

The Centers also serve as scientific resources for the biomedical community at large. Scientists from other institutions throughout the United States depend more and more on Primate Center resources and services. Collectively, the seven Centers assist approximately 1,300 investigators who use nonhuman primates as the most appropriate models for investigations on important human health problems. Many university departments and research institutions have drastically reduced and, in some areas, eliminated the use of primates because of requirements for higher standards and consequently higher costs for animal housing and the inherent difficulties in managing primate colonies and need for specially-trained personnel. It is not surprising that these institutions and their researchers are increasingly turning to the Regional Primate Research Centers as places to carry out their work. Additionally, the biotechnology revolution is creating a vast new group of bioengineered products that will be used to treat everything from heart disease to AIDS that can only be studied and tested in nonhuman primates. The full impact on Primate Centers is yet to be realized. The Primate Centers are having an increasingly difficult time in accommodating this valid and needed research. This trend has also taxed Center resources.

Research using primates has and is continuing to contribute to many important diseases of mankind. These include heart disease, which will claim over 500,000 lives this year in the United States; hypertension or high blood pressure, which affects one-third of our adult population; malaria, which at any given moment affects 100 million persons; leprosy, a disease affecting 15 million people and on the increase; Parkinson's disease, an illness which afflicts approximately a million individuals in this country; ulcerative colitis, which affects 300,000 to 500,000 Americans and places them at 15 to 30 times the normal risk of colon cancer; and, drug addiction which has been named a National Crisis. These are but a few of the maladies being studied at Primate Centers. Most recently, another National Crisis has been addressed by the Primate Center

Program - AIDS. I needn't elaborate on this National and International epidemic caused by a virus estimated to infect 1.5 million Americans and up to 10 million people worldwide. The Primate Centers' response to this catastrophe has been impressive. An excellent animal model has been developed and is presently being pursued to develop a vaccine and to better understand how the virus induces disease. The Primate Center effort, however, has further taxed Center resources at the expense of other programs.

The success of each of these programs is dependent on a stable operating budget. The core support, or base grant, to the Centers is the very heart of the Program to provide the primary source of funds to recruit and employ qualified researchers and support personnel and pay the necessary and ever-increasing costs to maintain a facility including heat, light and maintenance. The operating budget for the Primate Centers has not grown in real dollars for several years; in fact, the appropriations declined last year and the Administration Budget for FY 90 contains a further decrease.

There are two financially devasting circumstances that have a tremendous negative impact on the Primate Center Program. The FY 1989 appropriations reduction of 1.9% plus the further proposed FY 90 appropriation reduction of 1.2% will result in the actual loss of $1,353,000 from the core grant in just the past two years. If you factor in last year's inflation rate plus the projection for the coming year, real losses to the Primate Center core grants approach 4.9 million dollars (Table 1).

The second circumstance that has resulted in a negative financial impact on the Primate Center Program is that the actual core award in FY 1989 was 9.3 million, less than the N.I.H. recommended budget. The basis for this N.I.H. recommended budget involves the standard process of Primate Center site visits, peer reviews, and council deliberations. The loss of this 9.3 million means the Primate Centers have been denied funding for recognized, legitimate, approved research programs, people and equipment.

Just to maintain the status quo of FY 88, a congressional appropriation of $31,310,680 for the Primate Centers Core support is necessary and I urge Congress to recommend such an appropriation. I point out and, indeed emphasize, that the approved funding level as determined by the N.I.H. peer reviewers/study section/council mechanisms is over $35,184,805. The Administration budget for FY 90 recommends an increase in spending for all other N.I.H. programs. The irony of this is that while these specially designated monies are being appropriated for scientific research, the infrastructure at the Primate Centers to support these designated monies is allowed to be underfunded. Without an appropriately supported infrastructure, specially designated research program appropriations only place increased demands on the base operating funds that cannot adequately support them. An erosion of this infrastructure capability has significant long-term research consequences.

Further, the Primate Centers Program faces another financial crisis. The 90th Congress passed legislation requiring that the biomedical community provide for the psychological well-being of nonhuman primates. While the final regulations from the United States Department of Agriculture are not yet fully formulated, it is clear that they will require significant expenditures of money. Estimates run as high as $70,000,000 for Primate Research Centers alone. There is no provision anywhere to meet these newly imposed requirements. We urge Congress to initiate a five-year appropriation plan to meet these new regulations by providing $10,000,000/year to improve and upgrade animal facilities. This appropriation should also contain the provision for construction authority. For the past two decades, the Centers have maintained and attempted to upgrade animal facilities in a patchy and wholly inadequate manner. The time has come to construct state-of-art facilities.

I therefore ask the Committee to examine two issues very carefully:

ONE: Review the appropriation for the Primate Centers Program and make every effort to approach the N.I.H-approved funding level of 35 million dollars.

TWO: Initiate a five-year program with congressional authorization for construction without a requirement for matching funds at a level of 10 million dollars per year to construct housing and breeding facilities for animals, such that the Centers can meet the spirit of the Congressional legislation calling for improved facilities.

The directors of the seven Regional Primate Research Centers very much hope that members of the Senate Appropriations Subcommittee on Labor, Health and Human Services and Education will take our request under serious consideration in the interest of solving many of our nation's health problems.

TABLE I

CORE BUDGETS - PRC
(in millions)

FY 88	$26,322,000		
FY 89	25,828,000*		
		$1,040,000 Reduction	
FY 89	$25,828,000		
FY 90	25,515,000		
		$ 313,000 Reduction	
TOTAL ACTUAL DOLLAR LOSS TO CORE GRANT IN 2 YEARS:			$1,353,000
4% FY 89 Inflation Rate; loss of	$1,052,880		
10% Recent projection FY 90	2,582,800		
		Total Inflation Loss	$3,635,680
TOTAL LOSS (Inflation and Reduction)			$4,988,680

*N.I.H. Recommended Funding Level - $35,184,805

Senator **Specter**. Thank you, Dr. Hunt. Those are not easy issues, and we are grappling with them. We understand your request for additional funds. We are searching hard.

STATEMENT OF DR. DAVID MOLINE, UNIVERSITY OF IOWA, COLLEGE OF DENTISTRY, AMERICAN ASSOCIATION OF DENTAL SCHOOLS

Senator **Specter**. Now I would like to call Dr. David Moline, University of Iowa, College of Dentistry, with the American Association of Dental Schools.

Dr. **Moline**. Good morning. Thank you, Senator.

I am Dr. David Moline, director of the General Practice Residency Program and the division of family dentistry at the University of Iowa Hospitals.

Mr. Chairman, I would first like to discuss the urgent and critical need to increase support for the general dentistry programs. These residencies train dentists in the skills necessary to provide comprehensive care to a wide variety of patients, including the elderly, the handicapped, and the medically compromised.

Senator **Specter**. Do you have a prepared statement, Dr. Moline?

Dr. **Moline**. Yes; we do.

Senator **Specter**. Proceed, please. It will be admitted fully in the record.

Dr. **Moline**. Thank you. This includes treatments of individuals infected with AIDS and hepatitis, as well as preparation of those who will become immuno-compromised as a result of cancer, diabetes, and transplant therapies, to name just a few.

Like medical interns, these residents rotate through the various medical and dental disciplines, and learn hospital protocol and total patient care. Upon completion of this training, general dentistry residents can treat patients requiring more complex care which is especially important in rural and underserved urban areas where cost or distance may make referral to specialties impossible.

Unfortunately, however, one out of every three applicants for the general dentistry residencies is turned away because we do not have enough positions available. The University of Iowa Dental School will apply for fiscal year 1990 funding under the General Dentistry Program, but our chances for obtaining this grant support are limited if funding is not significantly increased.

Our frustration is common among the 57 dental schools and 500 hospital dental programs that must compete for the $2.6 million available.

It is important to remember that Medicaid and Medicare coverage for dental services is very limited or simply unavailable. Without Federal funding, new programs are nearly impossible to create because of the length of time needed for these programs to become self-sufficient.

Therefore, we urge the subcommittee to provide general dentistry an appropriation of $6 million in fiscal year 1990.

The other appropriations issue I wish to mention this morning concerns the unreimbursed costs we incur in providing oral health care to AIDS patients. Many of the first physical signs of AIDS are found in the mouth. Therefore, a dentist is often the first to diagnose the disease and refer the patient for care.

Dental schools and hospital dental programs see a significant number of AIDS patients, most of whom have no money and no insurance coverage. AADS estimates that these programs provided more than $15 million in unreimbursed care to AIDS patients last year. This has already resulted in the closure of two hospital dental programs on the west coast.

PREPARED STATEMENT

We urge an appropriation of $5 million in fiscal year 1990 to allow the initiation of a grant program to partially offset these unreimbursed costs.

Mr. Chairman, the American Association of Dental School and I thank you for this opportunity.

[The statement follows:]

STATEMENT OF DR. DAVID MOLINE

I am Dr. David Moline, Director of the General Practice Residency Program and the Division of Family Dentistry at the University of Iowa. I am past national president of the Academy of General Dentistry and a past member of the Board of Regents of the National Library of Medicine. I appear today on behalf of the American Association of Dental Schools (AADS), which represents all of the nation's dental schools as well as advanced education institutions, hospital dentistry and allied dental education programs.

The role of dentistry is expanding, and reflects the changing nature of the profession. Today, dentists are researching and treating complex oral diseases as well as oral responses to systemic diseases. Dental scientists must keep pace with technology as they research cell and molecular biology techniques to yield insights into cell behavior and genetic regulation. Dentists are treating more medically compromised patients including those afflicted with serious immune system deficiencies. As dentistry explores an ever-widening range of diseases and disorders, the need for a pool of well-trained researchers and practitioners becomes paramount. The future holds no great dental research if we fail to upgrade the curriculum, develop faculty, and train students for tomorrow's challenges.

This statement describes the AADS funding recommendations for health professions training programs especially important to dental education.

General Dentistry Residencies: There is a pressing need to increase support for general dentistry programs in FY 1990. General dentistry programs provide dental graduates with the didactic skills and clinical experience necessary to provide comprehensive care to a wide variety of patients requiring specialized or complex care, including the elderly, the handicapped, the medically compromised, and those infected with the AIDS virus.

Dentists who have had the benefit of this advanced training are better prepared to provide comprehensive dental services, and rely less on specialists. The availability of dentists who can serve a broad range of patient needs is especially critical in rural areas.

While such a residency is not yet required for licensure in dentistry (as is the comparable internship year in medicine), nearly 34% of dental graduates across the country voluntarily seek such training. Yet, in 1988, one out of every three applicants for General Dentistry residency training was turned away.

The General Dentistry program is presently funded at $2.6 million, which is woefully inadequate to meet the need for these residencies. Fifty-seven schools and over 500 hospitals must compete for General Dentistry funding; the schools alone would need $30 million in FY 1990 to meet their goals for initiation or expansion of General Dentistry programs. The limited level of Federal funding provided for the General Dentistry program, however, has meant that most of these schools have had to delay adding General Dentistry residencies. No other Federal support is provided for dental programs: Medicaid and Medicare are limited or simply unavailable. Without Federal support, it would be impossible to create new programs because of the lead time needed for these programs to become self-sufficient, and because of the high cost of dental equipment and instrumentation.

To cover expansion of current programs as well as start-up funds for new programs, we urge the Committee to provide General Dentistry the FY 1990 authorized level of $6 million.

Acquired Immune Deficiency Syndrome (AIDS): AIDS patients, as a group, suffer a high incidence of oral disease. Thirty percent of the first physical manifestations of HIV infection are found in the oral cavity; therefore a dentist is often the first diagnostician to see the patient. As a result of the immune system breakdown that occurs, AIDS patients are more susceptible to very severe oral herpes, rampant fungal diseases, hairy leukoplakia, as well as oral disease found only in patients who suffer from AIDS, including HIV-gingivitis and HIV-periodontitis-- an extremely painful form of gum disease that frequently involves complete necrotic breakdown with exposure of the bone. Severe pain in the oral cavity is frequently the symptom that leads these patients to seek care.

Dental education institutions that become known as referral centers for AIDS patients risk serious fiscal problems, because the patients they serve have complicated treatment needs, requiring more resources than the "average" dental patient. Moreover, oral health care is not covered under many private insurance programs, and is partially covered at best under Medicaid. AADS estimates that dental schools and hospital-based dental residency programs provided more than $15 million in unreimbursed care to AIDS patients in the past year.

The 1988 Health Professions Training Act established a new Section, "Training with respect to AIDS". Subsection 788 B (f), "Dental Schools", authorizes the funding of grants to partially offset the unreimbursed costs incurred by teaching programs providing oral health care to patients with AIDS. Such a "matching fund" would alleviate some of the financial burden faced by these treatment centers, allowing some centers to stay open despite chronic under-reimbursement.

AADS urges an appropriation of $5 million in FY 1990 to allow the initiation of this much needed program.

Geriatric Education Centers and Geriatric Training: Geriatric Education Centers (GECs) provide short-term faculty training, curriculum and other educational resource development, technical assistance and outreach. These programs are multi-disciplinary in nature, and are affiliated with other educational institutions, hospitals, nursing homes, community based centers for the aged, and/or Veterans Administration hospitals. Many of the GECs provide geriatric evaluation units that serve as centers for clinical training. In addition, health practitioners are provided continuing education, and health professions students rotate through GEC clinics.

In FY 1989, 33 GECs throughout the United States received almost $10 million; the AADS recommends that the Geriatric Education Center program be funded at the FY 1990 authorized level of $10 million to continue this effort.

The Geriatric Training program provides for one- and two-year post doctoral fellowships for medical and dental faculty. In enacting this authority in 1987, Congress responded to the need for in-depth training of faculty in geriatrics. Recent evaluations of the adequacy and availability of health care personnel to meet the needs of elderly Americans through the year 2020 have revealed a shortage of adequately-trained faculty to train future health care providers in geriatrics. The $4 million provided in FY 1989 supported the initial planning year for the 23 Geriatric Training programs, including the development of curriculum, hiring of faculty, and the first three months of fellowship training. Additional funds are necessary to cover stipend costs in FY 1990, as the Geriatric Training programs expand and become fully operational with two classes of fellows.

AADS urges the provision of $7 million in FY 1990 for Geriatric Training. This would support the initiation of fellowships for approximately 150 academicians and researchers who will return to their home institutions formally prepared to effect changes to the curricula and patient care delivery systems that are essential to accommodate the anticipated needs of the elderly, and to direct research projects addressing the health care problems of the aged.

Disadvantaged Assistance: Disadvantaged Assistance programs are designed to recruit under-represented minorities into health professions schools, to assist them in preparing to enter these schools, and to retain them once they are admitted. Despite some success, significant under-representation still exists. This in turn has created serious problems in the delivery of health care to our nation's Black and Hispanic citizens, which will be exacerbated without continued and increased federal support.

Health Career Opportunity Program (HCOP) institutional grants may be credited with keeping the percentages of Black and Hispanic students stable during the past several years. Also available under the Disadvantaged Assistance authority are grants to needy medicine, osteopathy, and dentistry students. Termed "Financial Assistance to Disadvantaged Health Professions Students", these grants complement institutional recruitment/retention efforts by providing disadvantaged minority students some financial assistance. The disparity between the number of minority students graduated from dental school and the number that would be required to achieve proportionate representation will grow unless adequate resources are made available to address this problem. The AADS recommends that the Disadvantaged Assistance program be funded at the authorized level of $34 million in FY 1990.

Exceptional Financial Need: Most health professions students must incur significant debt in order to complete their training. In 1988, the average senior dental student graduated owing $39,300. Many students are reluctant to incur such debt, but minority students from low-income families are especially fearful of borrowing thousands of dollars worth of student loans.

The Exceptional Financial Need (EFN) program provides scholarships for students with no financial resources so that they are not forced to assume high levels of debt in order to pursue a health professions career. The EFN program was recently broadened to cover not only first-year students, but those in all years of health professions training. In 1987, over $21 million would have been required to provide scholarships to all eligible first-year students. DHHS officials estimate that the number of eligible applicants this year will increase fivefold. For this reason, AADS asks that the EFN program be funded at the FY 1990 authorized level of $30 million.

Health Education Assistance Loan (HEAL): Our Association is very concerned that the Health Education Assistance Loan program remain a viable "loan of last resort" for dental students. Students pay the market rate for these unsubsidized loans and are assessed an insurance fee to offset defaults. Since the inception of the HEAL program in 1979, nearly 15,000 dental students have borrowed approximately $276 million through the HEAL program to finance a portion of their dental education. Without HEAL loans, many students would be forced to discontinue their training.

The HEAL program costs, to date, have been borne entirely by participating borrowers, and the goal has been to avoid the need for an appropriation for this program. DHHS is currently assessing the sufficiency of the Student Loan Insurance Fund (SLIF), taking into account the large number of loans just entering repayment, as well as numerous program management requirements recently mandated by statute and regulation. While DHHS develops a reliable forcast of the SLIF's future appropriation needs, if any, AADS urges Congress not to restrict access to HEAL borrowing. Even if the low insurance premiums charged during the program's initial years created a shortfall in the SLIF, such a situation should not result in diminished access for today's students who pay an 8% insurance fee. We ask the Subcommittee to insert language in the FY 1990 appropriations bill that will allow credit guarantees of up to $330 million in HEAL loans for fiscal year 1990.

Research: AADS endorses the testimony of the American Association for Dental Research regarding priorities and funding for the National Institute of Dental Research and the National Center for Health Services Research. We also endorse the recommendations of the American Dental Association concerning the National Center for Health Statistics and the Dental Disease Prevention Activity of the Centers for Disease Control.

Within the NIDR budget, AADS especially wants to note our concern about the Biomedical Research Support Grant, Academic Research Enhancement Award, and Institutional Research Service Award programs. We urge the Subcommittee to reject the Administration's proposed treatment of these important programs, and instead provide sufficient funding so that pilot research projects, recruitment of scientists, and training of individuals in specified shortage areas can be continued.

We thank you for this opportunity to testify on the FY 1989 appropriations and for the substantial efforts members of this Subcommittee have undertaken to benefit the health of the American people. AADS would be pleased to respond to any questions you may have.

Senator SPECTER. Well, we very much appreciate your testimony, Dr. Moline, and we will look at your request very carefully. Thank you.

Dr. MOLINE. Thank you.

STATEMENT OF JOHN C. THIEL, EXECUTIVE DIRECTOR, AMERICAN DENTAL HYGIENISTS' ASSOCIATION

Senator SPECTER. I would like now to call on Mr. John Thiel, American Dental Hygienists' Association.

Welcome, Mr. Thiel. We have your statement. It will be made a part of the permanent record. You may proceed.

Mr. THIEL. Thank you, Senator. I am John Thiel. I am executive director of the American Dental Hygienists' Association. On behalf of the American Dental Hygienists' Association, I want to thank you for this opportunity to testify in support of fiscal year 1990 appropriations for the Department of Health and Human Services, especially the National Institute of Dental Research.

Organized in 1923, the American Dental Hygienists' Association represents 30,000 members across the Nation dedicated to assuring the highest level of preventive dental care.

Mr. Chairman, dental hygienists today play a vital and cost-effective role in the delivery of oral health services, similar to the evolving role initially played by registered nurses in the delivery of medical services. Dental hygienists perform numerous preventive and therapeutic services. They are involved in direct patient care, including patient education, review of medical and dental histories, formulation of health promotion activities, and initial therapy recommendations.

As the foremost prevention professional in the dental care team, hygienists are licensed providers. We recognize the continued research at NIH as critical to the future of prevention. The National Institute of Dental Research has helped to revolutionize our knowledge and our provision of dental health care.

Through NIDR-sponsored research we have done the following: We have identified the major cause of certain forms of dental caries; we have validated the importance of fluoride in oral health regimens; we have been able to work toward a vaccine against dental caries; we have improved adhesive sealants to protect teeth from the ravages of dental caries; we have identified the link between good nutrition and good oral health; and we have demonstrated the importance of education and promotion activities in assuring good oral health.

Despite these successes and last year's increase in funding for the Institute, funding for NIDR has not been commensurate with the research need, as reflected in the NIDR long-range research plan. While the administration's fiscal year 1990 budget plan recommends a modest increase for NIH and NIDR, it is not sufficient to maintain current research momentum. NIH funding must increase by over 12 percent in fiscal year 1990 to achieve the same level of effort as in fiscal year 1989.

The ADHA endorses a budget of $171.9 million for NIDR, a budget which would allow NIDR to proceed with timely implementation of its long-range plan. This recommendation is also consistent with those of the Ad Hoc Coalition for Medical Research Funding, which has recommended $8.4 billion for all of NIH for fiscal year 1990.

In addition, ADHA recommends that the appropriation for the Centers for Disease Control should include funds to allow the Director of the Center for Prevention Services to allocate $1.5 million for the dental disease prevention activity. The DDPA is a vital support mechanism which provides a national focus for the control and prevention of oral diseases such as dental caries, periodontal disease, and oral cancer.

Last year Senator Kennedy introduced Senate Bill 2229, the Health Professions Reauthorization Act of 1988, which was a comprehensive legislative initiative put forward to address the health care needs of our Nation through increased support for the education of allied health professionals.

Unfortunately, critical portions of that bill relating to allied health were not included in the final legislation which passed and was signed into law last year as part of the Health Omnibus Extension Act of 1988. In addition, much of what was included was authorized funding levels much lower than those in the Senate-approved version of Senate Bill 2229.

Accordingly, ADHA joins the American Society of Allied Health Professions in recommending that at a minimum this subcommittee include $2 million for traineeships for advanced training of allied health personnel, $2 million for allied health grants and contracts, and $2 million for a new loan repayment program for allied health personnel.

In conclusion, Senator Specter, the members of the American Dental Hygienists' Association appreciate the important contributions that this committee has made to improving the quality and availability of dental health care services throughout the country.

We sincerely hope that the committee will continue to support preventive health programs as the most responsible approach to a long-term reduction in national health care expenditures.

Again, we thank you for the opportunity to present our views.

Senator SPECTER. Thank you very much, Mr. Thiel. We shall take a close look at your request.

[The statement follows:]

STATEMENT OF JOHN C. THIEL

The American Dental Hygienists' Association ("ADHA") appreciates this opportunity to present its recommendations regarding FY 1990 Appropriations for the Department of Health and Human Services ("HHS"), and in particular, the National Institute of Dental Research ("NIDR"). Organized in 1923, ADHA represents 30,000 members across the country dedicated to assuring the highest level of preventive dental care. Originally formed to develop communication and mutual cooperation among hygienists, ADHA today serves as an advocate for dental hygienists at the federal, state and local levels.

ADHA's mission, "to improve the public's total health by increasing the awareness of and access to quality oral health care," reflects the professional goals of ADHA's membership. As the foremost prevention professional on the dental care team, dental hygienists are licensed providers.

Today, dental hygienists play a vital cost-effective role in the delivery of oral health services, similar to the evolving role initially portrayed by registered nurses in the delivery of medical services. Dental hygienists perform numerous preventive and therapeutic services. As contributing professionals in the delivery of oral health care services, dental hygienists are involved in direct patient care, including but not limited to, patient education, review of medical/dental histories, formulation of health promotion activities, assessment of soft tissue health, prophylaxis, x-rays, soft tissue curettage, root planing, local anesthesia, and initial therapy recommendations.

THE STATE OF AMERICAN DENTAL HEALTH

The role of these activities in achieving optimal dental health is impressive. We have been witness to a fifty-percent decrease in tooth decay overall, and one third of American grade-school children are now cavity free. Indeed, research scientists suggest that elimination of most major dental diseases may be possible within the lifetime of oral health professionals now practicing. The recent national survey conducted by the National Institute of Dental Research ("NIDR") regarding adult dental health indicates that America's teeth are in better shape than ever, though some population groups still are in need of special dental attention. The survey results also suggest that the tremendous progress that has been made in the dental health of children has begun to carry over into the middle-aged population.

Yet a great deal remains to be done, especially among our elderly. The survey found that seniors had a 63 percent incidence of root caries, compared with a 21 percent incidence among employed adults. In addition, 42 percent of seniors surveyed were missing all their teeth, while only 2 percent had retained all permanent teeth.

Indeed, we are still far from the ultimate goal of total prevention:

- Overall, Americans are spending $20 billion a year for treatment of their dental and oral problems;
- Americans lose 32 million days of work due to dental problems, costing the American economy $3 billion in lost wages. Amazingly, this economic statistic does not even include losses in productivity;

- 23 million Americans are missing all of their teeth;
- Despite reductions in dental cavities, the average American child has at least one cavity lesion by age 8; 4 by age 12, and 11 by age 17.

Counterbalancing these gloomy figures, though, is the promise of prevention. Research has shown that at least one form of cavities (coronal caries which attack the crowns of teeth) is preventable. Moreover, the National Institute of Dental Research ("NIDR") Long-Range Research Plan for FY 1985-1989 has stated that, "fluoride regimens and adhesive sealants, combined with good oral hygiene and wise eating habits, can prevent tooth decay in normally healthy individuals." Herein lies the true value of the hygienists' mission: as the lead advocates, spokespersons and educators in preventive oral health care, we can do something about preventable disease today.

In battling preventable oral disease, the federal government provides three major services. Knowledge about the causes of dental diseases and preventive techniques can be increased through basic biomedical research. Improved methods of health care delivery can be identified, tested and qualified. Delivery of health care services to populations without adequate access to dental care and dissemination of new techniques can be achieved. In these efforts, the Congress can provide assistance through adequate funding of the National Institute of Dental Research and the Centers for Disease Control's Dental Disease Prevention Activity.

NATIONAL INSTITUTE OF DENTAL RESEARCH ("NIDR")

Founded in 1948, NIDR has helped to revolutionize our knowledge and provision of dental health. In identifying the causes of preventable dental diseases and the appropriate strategies to combat these maladies, NIDR has led the way. Through NIDR sponsored research, we have:

- identified the major cause of certain forms of dental caries;
- validated the importance of fluoride in oral health regimens;
- been able to work towards a vaccine against dental caries;
- improved adhesive sealants to protect teeth from the ravages of dental caries;
- identified the link between good nutrition and good oral health; and
- demonstrated the importance of education and promotion activities in assuring good oral health.

Despite these successes, and last year's increase in funding for the Institute, funding for NIDR has not been commensurate with the research need. Although the Long-Range Plan indicated a budget need of $174.5 million for NIDR in FY 1989, plan implementation has been slowed, in part due to recent budgetary restrictions which have affected all of NIH. Thus, a budget for FY 1990, which would allow NIDR to proceed with implementation of the Long-Range Plan, would provide NIDR with $171.9 million for the upcoming fiscal year.

While the Administration has in fact proposed an increase of 3.6 percent for the overall NIH budget - exclusive of AIDS-related support - the Department of Health and

Human Services estimates that, for the second consecutive year, significantly fewer new and competing research grants would be funded in FY 1990. Specifically, it is estimated that the number of new and competing grants would fall by 572, or 11.2 percent, under the Administration's budget request. In FY 1989, the number of approved grants dropped by 14.8 percent, from 6,018 in FY 1988 to 5,128. To make matters worse, NIH was forced to reduce the dollar amount of grant awards by an average of 10 percent. In 1990, it is projected that there will be an additional 9 percent cut in competing grants awards and a 10 percent cut in noncompeting awards. Moreover, only 3 out of 10 approved research grant applications at NIH will be funded in FY 1989. Despite the Administration's proposed increase in NIH and NIDR funding, it will not be sufficient to allow medical research to keep pace with research opportunities.

TITLE VII OF THE PUBLIC HEALTH SERVICE ACT

Last year, Senator Kennedy introduced S.2229, the Health Professions Reauthorization Act of 1988, a comprehensive legislative initiative put forward to address the health care needs of our Nation through increased support for the education of allied health professionals. Unfortunately, critical portions of that bill relating to allied health were not included in the final legislation which passed and was signed into law late last year (P.L. 100-607, the Health Omnibus Extension Act of 1988). In addition, much of what was included was authorized at funding levels much lower than those in the Senate-approved version of S.2229. Accordingly, ADHA joins the American Society of Allied Health Professionals in recommending that, at a minimum, this Subcommittee include $2 million for traineeships for advanced training of allied health personnel, $2 million for allied health grants and contracts, and $2 million for a new loan repayment program for allied health personnel.

COMMUNITY AND MIGRANT HEALTH CENTERS

The Community and Migrant Health Centers ("CMHC") grant program is designed to support facilities that provide comprehensive primary health care services as well as preventive and educational programs to medically underserved areas and migrant workers. In order to qualify for Community grants, facilities must meet certain criteria regarding scope and type of services provided, populations served, and the nature of the geographic area to be served. The Migrant grants are awarded to facilities which can best serve the unique needs of migrant workers. Unquestionably, these facilities provide basic health care to a segment of the American public which would otherwise not receive proper health care due to financial, occupational, and/or geographic factors.

Because these centers provide important preventive dental care services, ADHA recommends that the CMHC grant program receive funding commensurate with the full FY 1990 authorization level. Moreover, we believe that the National Health Service Corps ("NHSC") should receive sufficient funding to insure the highest level of quality care at the CMHCs.

CENTERS FOR DISEASE CONTROL

The Dental Disease Prevention Activity ("DDPA") funded through the Centers for Disease Control ("CDC") is a vital support mechanism for state dental health programs. The DDPA provides a national focus for the control and prevention of oral diseases such as dental caries, periodontal disease, and oral cancer. As the national leader in dental disease control and prevention, the DDPA provides consultation, training, promotional and educational support, disease surveillance, and other technical services to state and local governments and other professional, educational, and citizen organizations.

Although the DDPA is not a line item in the President's FY 1990 budget proposal, the CDC appropriation should include funds to allow the Director of the Center for Prevention Services to allocate $1.5 million for the DDPA. ADHA's recommendation would allow the DDPA to resume and enhance its mission in education and health promotion - a mission which recently has been sorely neglected.

CONCLUSION

The 30,000 members of the American Dental Hygienists' Association appreciate the contribution this Committee has repeatedly made to improving the quality and availability of dental health care services throughout this Nation. We hope that the Committee will continue to support preventive health programs as the most responsible method for long-range reduction in national health care expenditures. In this regard, we hope Committee members will seriously consider these specific funding recommendations. Again, we appreciate the opportunity to present our views.

STATEMENT OF LEE DUCAT, NATIONAL DISEASE RESEARCH INTERCHANGE (PENNSYLVANIA)

Senator SPECTER. I would like now to call on Ms. Lee Ducat, an old friend of mine—or a friend of mine of some longstanding, who is a young friend of mine.

Ms. Ducat has been instrumental in the National Disease Research Interchange work on diabetes, and I am pleased to note her efforts at founding the National Coalition for Science Alternative Resources.

Your testimony will be included in full in the record, even the part which contains my colloquy with Senator Chiles from last year.

Ms. DUCAT. Thank you. Senator Specter, I cannot tell you how grateful and honored I am to be able to testify to you. This is a very rare occasion, and it gives me the opportunity to thank you in person for your courage and your strength and your vision in the support of medical research which I feel has helped my son and the kids across the country who have diabetes, and for your strong support of alternatives, the new emerging alternatives to animal research.

So, this is a very unusual occasion for me, and I could not let it pass without giving you my deep and personal thanks.

Senator SPECTER. Thank you very much.

Ms. DUCAT. As you know, I started the Juvenile Diabetes Foundation in 1970 in Philadelphia and now it is a formidable organization with chapters all over the world, doing lots of really good things.

Then, in 1980 in Philadelphia again—our home State—I started the National Disease Research Interchange. The reason this National Disease Research Interchange was started was to look at alternatives to animal research. Now we are serving some 550 researchers. We have been able to collect waste castoff tissue, human tissue—about 40,000 tissues and organs and have been able to deliver them to researchers all over the country with some tremendous impact.

Now, for the first time, researchers are seeing human kidneys—for the first time. There is a possibility that the human retina could be transplanted and restore sight to people who are either having vision problems or who are blind.

There is also research in the regeneration of the optic nerve, which miracle or all miracles, might some day restore sight to the blind.

There is human pancreas transplant, the beta cells of the pancreas. Islet cell transplant, ongoing clinical trials right now, and we have been able to deliver some 25 million islets to some 40 researchers throughout the country, giving these researchers the ability to study the islet cells of the pancreas in an ongoing organized way.

I come to you today representing a newly formed coalition, and represent some hundreds of organizations and some thousands of people across the country. This coalition we call the National Coalition for Scientific Alternative Resources.

We have banded together to emphasize the importance of this new and exploding field. Does what happens in an animal happen to Arlen Specter? Senator? Does what happens in a mouse happen to Lee Ducat?

We are not sure, and the research using human tissue and using the many exploding alternatives that are now being used in the laboratory are causing some doubts as to whether what happens in a mouse happens to Senator Specter.

Animals are very essential and vital to basic research and they will continue to be. But we are now in a space age world. In fact, I think the *Challenger* is landing right at this moment, and I hope very safely. We have satellites orbiting planets, and *Challenger* orbiting the Earth. We need space medicine, science, and resources right here on Earth. These new scientific alternative resources are the space age.

Scientists cannot do their research without the proper resources, and right now computer technology and modeling and graphics and human tissue, its derivatives, cell cultures, and immortal cell lines can be established and researchers can use these little bits and pieces of us who are human beings in their own laboratories.

I urge that you continue your strong effort in your support of NIH. We need an appropriation this year of $8.4 million. I urge that the President's proposal for the Division of Research Resources be raised. It is about 16 percent too little.

We recommend that $478 million be appropriated to the Division of Research Resources. Resources serve all of research, and there needs to be a central focus on research resources in the National Institutes of Health, and a very strong one.

PREPARED STATEMENT

We recommend that alternative resources be separated out from the Animal Resource Division as a separate division, completely on its own, with the funding of approximately $30 million so that at this turn of the century we can begin to take advantage of the science which is within our grasp and solve the ills of the millions in our country who are suffering from diseases like AIDS and cancer and diabetes.

I thank you, Senator, for everything that you have done. As a daughter of Pennsylvania, I am very proud to be able to testify to you today and I am very proud that you are our Senator.

Senator SPECTER. Thank you very much, Lee. I very much appreciate your testimony. The committee last year inserted report language on alternatives to animals and research. It was adopted by the full Congress. We have your request and we shall search hard to see if we can find the money. It is not easy, but you know that.

Ms. DUCAT. Thank you.

[The statement follows:]

STATEMENT OF LEE DUCAT

I am Lee Ducat, Founder and President of the National Disease Research Interchange (NDRI), a nonprofit, tax-exempt organization, whose sole purpose is to work in conjunction with the National Institutes of Health and others toward ensuring that researchers throughout the Nation have access to the human tissues and organs that are so vital in achieving breakthroughs that will lead to the prevention, treatment, and cure of so many diseases. I have also served on the Diabetes Commission, two National Diabetes Advisory Boards and as a member of the Task Force on Organ Transplantation.

I am pleased to announce to you today that I have recently founded the National Coalition for Scientific Alternative Resources, a consortium of organizations and individuals that have banned together for a common goal: the establishment of a Division for Alternative Resources within the Division of Research Resources (DRR) at the National Institutes of Health (NIH). A list of the founding members and organizations accompanies this testimony.

The Coalition represents those organizations on the cutting edge of new technologies for alternative resources to using animals in research, that will lead the way for researchers into the 21st Century. While the Coalition recognizes that research utilizing animals has and will continue to be essential to our making progress in the war against diseases, the fact is today, the world of alternative research resources is exploding with promising new ways to look at old diseases. In this the computer age, scientific labs have the capacity to utilize existing biotechnologies such as magnetic resonance imaging, spectroscopic analysis, and electronic scientific bulletin boards, and to work in the biomedical field of discarded human tissue and its dirivatives, cell cultures, and immortal cell lines. As the Coalition looks towards the future, it sees scientists unable to conduct competitive and complete research without these resources.

Now is the time to focus on the new alternatives that have burst recently onto the scientific scene. NIH must move with these new biomedics and biotechnologies into the future. With these new advances, the Coalition believes strongly that the President's budget request for the Division of Research Resources of $263,313,000 is inadequate. A 16.3 percent decrease from the 1989 level is simply unacceptable. The Coalition further recommends that the Committee provide NIH, as a whole, funding of $8.416 billion in Fiscal Year 1990.

The Coalition believes that in order for DRR to be able to continue to meet its mandate and provide the leadership which is crucial to our national research effort, an appropriation level of $479.283 million is necessary for Fiscal Year 1990. For the support of alternative resources, we recommend $30 million in funding. Most importantly, the Coalition urges Congress to establish a Division for Alternative Resources within DRR, separate and distinct from the Animal Resources Program, to focus on the new, the different and the unusual alternative resources which might just lead to the discovery of new drugs, new genes, new treatments or new cures for the millions suffering from disease.

Our Nation's pioneer spirit has put a man on the moon, sattelites into space and spacecraft into the outer reaches of our expansive universe in search of new discoveries. We must now channel that pioneer spirit into developing the latest alternative resources so that our scientists can accelerate the discovery of treatments and preventions for diseases like AIDS, Cancer and Diabetes. We can no longer rely upon antiquated resources as we move into the next Century.

The fact is, using the latest biomedics and biotechnologies, scientists are beginning to unravel the physiological and chemical makeup of the human kidney, which may lead to exciting new medical break-throughs. Researchers are now, for the first time, working on the transplantation of retinas to restore sight. Through human pancreas donations, some 37 researchers across the country are studying pancreatic cells on a regular basis and some 25,000,000 islet cells have been distributed to scientists for their study. Discarded cancerous tumors are now being retrieved for analysis and study with great hope for a breakthrough in Cancer research.

You and your colleagues in Congress have already begun recognizing the importance of developing alternative resources at DRR as reflected in the Division's legislative history. First, NDRI and the Coalition is deeply appreciative of the language included in last year's Senate Report which states:

> "The Committee reiterates its strong support for the development and utilization of alternative research models which do not rely on the use of animals. One such alternative is the National Disease Research Interchange (NDRI), whose mission is to ensure regular access to human tissues and organs for biomedical researchers thought the country. Breakthroughs in the treatment and cure of many diseases can be expected through the development of these alternative resources. In addition, it is the Committee's intention that NIH continue to develop resources which do not require the use of animals in research experiments." (138).

Second, when the full Senate adopted the Appropriations Labor, Health and Human Services and Education Subcommittee's Conference Report last year, former Subcommittee Chairman Lawton Chiles and current ranking member Senator Arlen Specter engaged in a very constructive dialogue, recognizing the importance of the alternative resource research community, and NDRI as one of the instrumental organizations funded through DRR serving the research community as an alternative resource mechanism. The following is excerpted from their colloquy:

> MR. SPECTER.
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> * * *
>
> I believe Senator CHILES and I share a common concern of vital interest to the health care and research community: the future of the research programs and organizations currently funded through the Division of Research Resources at the National Institutes of Health designed as alternatives to using animals as research and experimental resources. Such excellent organizations as the National Disease Research Interchange and the American Type Culture Collection and programs conducted at facilities such as the MIT Cell Culture Center, the Yeast Genetic Stock Center at the University of California Berkeley and the matrix of biological knowledge pilot project at the Unisys Corp., do outstanding work with funding through the Division of Research Resources. We would not, for example, be benefiting today from the accelerated gains

> made in diabetes and cancer research and treatment were it not for the alternatives the Division of Research Resources has developed to animal research resources.
>
> In light of the success rate of these existing programs and organizations, I urge that the Division of Research Resources allocate at least $10 million to enhance the current programs and organizations it currently funds, as well as new programs that are designed as alternatives to using animals as a research resource. Furthermore, I urge that of this amount, at least $3 million be allocated for the National Disease Research Interchange.
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> * * *
>
> MR. CHILES.
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> * * *
>
> I concur completely with the thrust of my colleague's statement and would like to add simply that we are on the cutting edge of medical breakthroughs with the use of biotechnologies such as magnetic resonance imaging, spectroscopic analysis, and electronic scientific bulletin boards to rapidly disseminate information on newly acquired research resources."

(Congressional Record, V. 134, No. 124, September 12, 1988, S12314).

The wave of the future is clearly in the direction of alternative resources. However, the point needs to be emphasized: the creation of a new division at DRR to support alternative resources is a pressing need. Such a division will not only corroborate research findings using animals, but it will also advance scientific understanding of those diseases for which no animal models exist. Your promotion of a Division for Alternative Resources within DRR will enhance and foster the current trends in emerging alternative resources now worthy of federal support.

On behalf of NDRI and the Coalition, thank you for allowing me this opportunity to present our views. I would be pleased to answer any questions you may have.

NATIONAL COALITION FOR SCIENTIFIC ALTERNATIVE RESOURCES

FOUNDING MEMBERS:

The Eye Bank Association of America

Mr. Tom Moore, Executive Director

National Disease Research Interchange

Ms. Lee Ducat, President
Keith Reemtsma, M.D., Chairman

Human Biological Data Interchange

Ake Lernmark, Ph.D., Chairman

Delaware Valley Transplant Association

Mr. Howard Nathan, Executive Director

Beta Cell Transplant Research Clinical Trials

Paul E. Lacy, Ph.D., Principal Investigator

The Center for Alternatives to Animal Testing at Johns Hopkins

Alan M. Goldberg, Ph.D., Director

Stanford Research Institute International

Charles Tyson, Ph.D., Director, Target Organ Toxicity

Cooperative Human Tissue Network, Eastern Division

Virginia LiVoisi, M.D., Principal Investigator

Human Tissue Resource, University of Maryland

James Resau, Ph.D., Director

STATEMENT OF JANET PARRISH, CHAIRPERSON, NATIONAL FUEL FUNDS NETWORK

Senator **Specter**. I would like to call on Ms. Janet Parrish, National Fuel Funds Network from Philadelphia. I am very pleased to see Ms. Parrish here. She is the chairperson of the National Fuel Funds Network, and we applaud your work. I do, especially, as one of your Pennsylvania Senators.

You may proceed.

Ms. **Parrish**. Good afternoon, Senator Specter, and thank you, too, for the invitation to be here and to testify today before this committee.

Before receiving the invitation I did submit written testimony to this subcommittee.

Senator **Specter**. Yes; we have your testimony and it will be made a part of the record in full.

Ms. **Parrish**. Thank you. Of course, in that testimony, once again it is a pleasure to bring before you our request of the urgency of the need for restoring funding for the Low Income Home Energy Assistance Program, the LIHEAP Program, in fiscal 1990 to the authorized level of $2 billion.

The National Fuel Funds Network, I should mention for the record, is a national membership organization. We currently have about 120 dues-paying members who represent about three-fourths of the States. These are operators of fuel funds like the Utility Emergency Services Fund, of which I am the executive director, as well as other community agencies, utilities, and others interested in the low-income-energy issue.

So, we believe we have a little bit of a grassroots national perspective on the problem.

Earlier Senator Hatfield asked one of the speakers for information on the scope of private sector support for deafness research. The person who was speaking was not quite sure, but thought that there was money in the range of $2 million. Well, I am prepared to tell you what the range of private sector giving is in support of the low-income-energy issue with the NFFN having just recently completed the most up to date national survey in this regard.

We got responses from about 121 fuel funds around the country. In fact, they came from about 45 of the States, plus the District of Columbia. They reported in the last year giving out approximately $31 million in assistance to about 200,000 households nationally.

Now, obviously this is not on a scale that is going to begin to make up for the cuts that we have experienced in Federal funding. On the other hand, having looked at prior surveys in this regard, it does indicate to me that there is a generosity in the private sector when it comes to low-income-energy needs, as well as a stability in this giving and support.

Now, notwithstanding the position of HHS, however, the need is not being met nationally. I am here to tell you today that even with the moderation in the energy prices that we have experienced, that low-income households are still having to devote some 15 percent of their income, or more, to paying home energy and heating costs.

I can, I think, best characterize what this energy burden means in the words of one of our clients who expressed to me the fact that it meant that she had to be very cautious, as she put it, with her budget. In fact, she said it is almost like putting yourself in prison.

Well, the States are not doing more with less. They are doing less with less. I think Pennsylvania is an important case in point, and I would also like to leave with you today some additional materials that do pertain to the Pennsylvania situation.

Senator SPECTER. We shall receive them and they will be made a part of the record.

[The information follows:]

HEATLESS = HOMELESS?

QUESTION: What happens when essential utility services are terminated and the household is unable to have them restored?

ANSWER: A great deal of valuable information is available through surveys performed each winter by local utility companies of those accounts terminated during the preceding year, whose service has not been restored. As this date illustrates, frequently properties are abandoned. And, in some cases, people continued to live in their homes without any source of heat whatsoever! Others resort to potentially dangerous space heaters or the use of the kitchen range.

	# off-accts surveyed	# vacant	#occupied and unheated	# utiliz altern htg srce
Dec. 1988				
PGW	6,228	1,519	923	2,016
PE	3,067	982	18	217
Dec. 1987				
PGW	7,172	1,149	794	1,946
PE	3,010	1,129	18	163
Water	5,500	1,100	n/a	n/a
Dec. 1986				
PGW	5,847	1,108	152	1,414
PE	2,420	767	15	62
Dec. 1985				
PGW	5,661	987	1,093	1,795
PE	6,807	2,597	31	441

Source: Reports of Philadelphia Gas Works and the PA Public Utility Commission's Bureau of Consumer Services. Verbal information from C. Weiss, Dep. Revenue Commissioner.

WHO THEY HELP

QUESTION: What are some of the demographic characteristics of that portion of the low income population presently receiving LIHEAP and/or Crisis benefits?

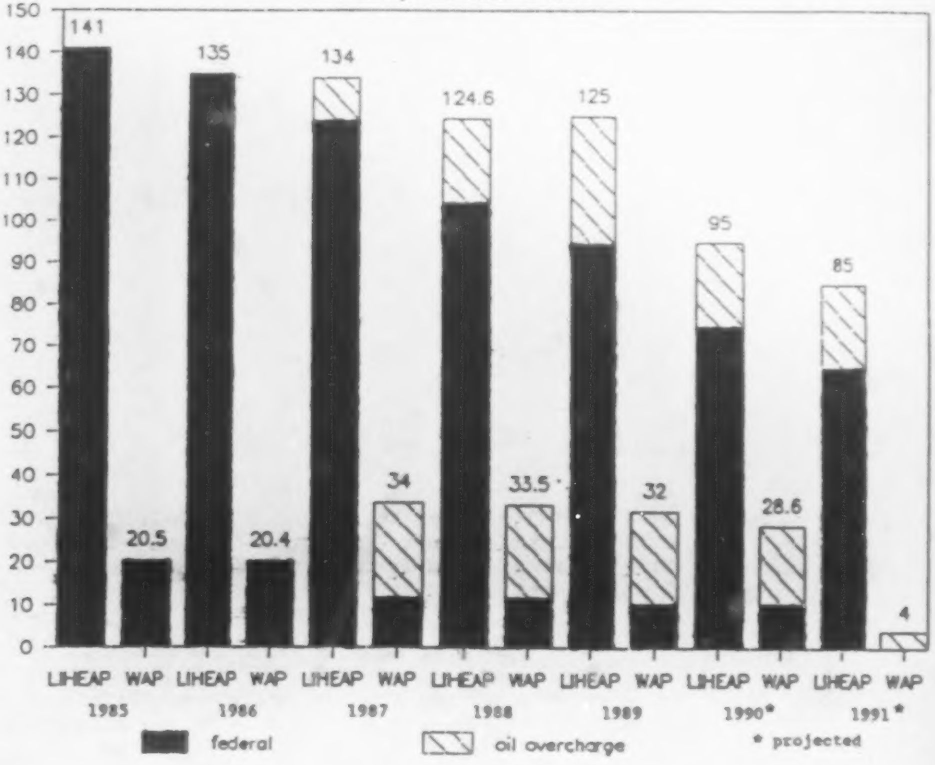
ANSWER: As illustrated in this chart, they are some of the neediest and most vulnerable of our citizens.

LIHEAP	CHARACTERISTICS	CRISIS
44%	Homeowners	41%
20%	Working Poor	30%
39%	Elderly	18%
11%	Disabled	12%
69%	Annual Income Less than $7000	57%
2.3	Average Household Size	3.1

Source: Pa Dept. of Public Welfare Statewide Demographic Reports (2/15/89)

Pennsylvania Funding for LIHEAP & WAP

Fiscal years 1985 - 1991



Ms. Parrish. We have already cut our average LIHEAP grant by some one-third over the past several years, and this year, of course, we were forced to cut income eligibility in the program from 150 down to 135 percent of poverty. This eliminated some 16,000 elderly and working poor households from the program.

What other impacts are we seeing? Well, as you know, Senator, I have been tracking for some years the impact in the city of Philadelphia in terms of housing abandonment and even homelessness, and I have here today the latest update on statistics derived from surveys done every year by our local utilities of properties where they have terminated service during the preceding year and it has not yet been restored by December of that year. Thousands of properties are found to be vacant and another thousand have families living in them with no heat whatsoever, and thousands more using potentially dangerous supplemental forms of space heat.

So, we see LIHEAP as well as our own fuel fund program as a preventive approach to the more serious problems of housing abandonment and homelessness.

I would like to leave you, I guess, with the fact that we too realize what it means to face a budget crunch. In fact, UESF is looking at perhaps having to reduce our services by some 20 percent next year because we simply cannot generate enough funds in the private sector to make up for Federal cuts.

PREPARED STATEMENT

Private contributors, potential contributors, want to know why isn't Government taking care of this, why isn't Government doing more? It is a question that I guess I must leave with this subcommittee.

Of course, I would be happy to answer any questions you may have.

[The statement follows:]

STATEMENT OF JANET PARRISH

THANK YOU FOR THE OPPORTUNITY TO SUBMIT THIS WRITTEN TESTIMONY, SUPPORTING RESTORATION OF FUNDING FOR THE LOW INCOME HOME ENERGY ASSISTANCE PROGRAM (LIHEAP) IN FFY 1990 TO THE MINIMALLY ADEQUATE LEVEL OF $2 BILLION.

THE NATIONAL FUEL FUNDS NETWORK (NFFN) IS A MEMBERSHIP ORGANIZATION COMPRISED OF 120 DUES-PAYING REPRESENTATIVES OF PRIVATE FUEL FUNDS, COMMUNITY ACTION AND OTHER SOCIAL SERVICE ORGANIZATIONS, UTILITIES, REGULATORS AND OTHERS, FROM THREE-FOURTHS OF THE STATES. THUS, WE REPRESENT A NATIONAL, GRASS-ROOTS LEVEL PERSPECTIVE ON THE DIMENSIONS OF THE ENERGY/POVERTY PROBLEM. OUR MEMBERS SHARE A COMMITMENT TO INCREASING THE FINANCIAL AND HUMAN RESOURCES AVAILABLE TO ADDRESS THE ENERGY NEEDS OF LOW INCOME HOUSEHOLDS. THE NFFN HAS BEEN IN EXISTENCE FOR FIVE YEARS, SERVING AS A CLEARINGHOUSE FOR INFORMATION EXCHANGE AND TECHNICAL ASSISTANCE FOR THE ONE HUNDRED-PLUS PRIVATE FUEL FUNDS THAT HAVE DEVELOPED IN RECENT YEARS, IN AN EFFORT TO SUPPLEMENT INADEQUATE LIHEAP FUNDING AT THE LOCAL LEVEL.

AS PRIVATE SECTOR, COMMUNITY-BASED EFFORTS TO PROVIDE LAST RESORT EMERGENCY ENERGY ASSISTANCE TO SOME OF OUR COUNTRY'S NEEDIEST AND MOST VULNERABLE CITIZENS, WE HAVE SEEN FIRST-HAND THE SERIOUS, NEGATIVE CONSEQUENCES OF ONGOING REDUCTIONS IN FEDERAL FUNDING FOR LIHEAP. ACCORDING TO A RECENT SURVEY WE CONDUCTED IN COOPERATION WITH THE EDISON ELECTRIC INSTITUTE AND THE AMERICAN GAS ASSOCIATION, OUR PRIVATE SECTOR FUNDRAISING EFFORTS CONTRIBUTE AT LEAST $31 MILLION ANNUALLY AS A CRITICAL SUPPLEMENT TO LIHEAP FUNDING ON BEHALF OF NEARLY 200,000 HOUSEHOLDS; YET THIS IS FAR FROM EVEN APPROACHING CLOSING THE GAP LEFT BY RECENT YEARS' DRASTIC FEDERAL FUNDING CUTS. THIS DOES, HOWEVER, INDICATE STABILITY IN THE PRIVATE SECTOR'S CONTRIBUTION DURING YEARS WHEN--BY CONTRAST--THE FEDERAL GOVERNMENT HAS SLASHED FUNDING BY 33%

ALTHOUGH WE HAVE FOUND THAT THERE ARE MANY GENEROUS INDIVIDUALS WHO CONTRIBUTE A FEW DOLLARS, OR MORE, EVERY YEAR TO HELP THEIR LESS FORTUNATE NEIGHBORS, WE ALSO FIND THAT MANY POTENTIAL CONTRIBUTORS--INDIVIDUALS AND CORPORATIONS ALIKE--WANT TO KNOW WHY

GOVERNMENT IS NOT FULFILLING ITS RESPONSIBILITY TO SUPPORT AN ADEQUATELY-FUNDED LIHEAP. THIS SENSE THAT GOVERNMENT IS NOT DOING ENOUGH TO ASSIST THE POOR WAS REFLECTED IN RESPONSES TO A RECENT NATIONWIDE GALLUP SURVEY, PUBLISHED FOR INDEPENDENT SECTOR AS GIVING AND VOLUNTEERING IN THE UNITED STATES. WE CAN RESPOND TO THIS VERY REAL AND LEGITIMATE CONCERN ONLY BY BRINGING IT DIRECTLY TO YOUR ATTENTION.

NOTWITHSTANDING THE MISLEADING USE OF STATISTICS BY THE ADMINISTRATION (WHICH REFERRED TO A WARMER WINTER TO "PROVE" THAT ENERGY COSTS ARE NO LONGER AS BURDENSOME TO LOW INCOME HOUSEHOLDS), WE REMAIN PAINFULLY AWARE THAT THE PEOPLE WE SERVE STILL HAVE TO DEVOTE 15% OF THEIR INCOMES TO COVER THEIR ENERGY BILLS--FOUR TIMES WHAT THE TYPICAL MIDDLE INCOME FAMILY MUST DO. FOR THE POOREST OF THE POOR, THE BURDEN IS EVEN HIGHER! MANY OF OUR MEMBER FUEL FUNDS REPORT IT WOULD TAKE ONE-THIRD OF THEIR CLIENTS' INCOMES TO COVER ESSENTIAL HOME ENERGY COSTS--CLEARLY, AN IMPOSSIBLE BURDEN.

WHAT, THEN, ARE THE RESULTS LOCALLY? YOU ARE ALREADY AWARE OF THE MANY STATES IN WHICH LIHEAP PROGRAMS HAVE HAD TO OPERATE A SHORTENED PROGRAM YEAR, SERVING FEWER HOUSEHOLDS THAN PREVIOUSLY, OR HAVE BEEN FORCED TO REDUCE FURTHER ALREADY INADEQUATE BENEFIT LEVELS, OR HAVE EXCLUDED NEEDY HOUSEHOLDS FROM HELP WITH THEIR HEATING BILLS THROUGH REDUCTION OF INCOME ELIGIBILITY MAXIMUMS. THIS IS TRUE EVEN WHERE OIL OVERCHARGE FUNDS HAVE BEEN USED TO SUPPLEMENT FEDERAL LIHEAP FUNDS. OUR MEMBERS REPORT THAT SUCH PROGRAM CUTBACKS RESULT IN EVEN GREATER DEMAND FOR OUR VERY LIMITED AND SEVERELY-STRAINED PRIVATE SECTOR RESOURCES.

AND, WE HAVE BEGUN TO DOCUMENT EVEN MORE SEVERE CONSEQUENCES OF FEDERAL FUNDING CUTS. DUE TO THEIR INABILITY TO PAY THEIR ENERGY COSTS BY THEMSELVES OR WITH THE MINIMAL ASSISTANCE AFFORDED BY LIHEAP, MANY HUNDREDS OF THOUSANDS OF LOW INCOME HOUSEHOLDS SUFFER TERMINATION OF THEIR HEAT AND UTILITY SERVICES, OR LOSS OF OTHER HEATING FUEL SUPPLIES. YOU ARE WELL AWARE OF THE LIFE AND HEALTH-THREATENING HARDSHIPS THAT CAN RESULT. BUT, WERE YOU ALSO AWARE THAT SUCH LOSS OF SERVICE CAN RESULT IN FAR TOO MANY CASES IN

ABANDONMENT OF PROPERTIES, WITH ITS CONCOMMITANT DETERIORATION OF NEIGHBORHOODS AND CITIES AS A WHOLE.

STATISTICS COMPILED IN PHILADELPHIA OVER THE PAST SEVERAL YEARS DEMONSTRATE A CASE IN POINT. ANNUAL SURVEYS ARE PERFORMED IN DECEMBER OF EACH YEAR OF THOSE ACCOUNTS TO WHICH GAS AND/OR ELECTRIC SERVICE HAS BEEN TERMINATED DURING THE PRIOR YEAR BUT NOT YET RESTORED. RESULTS FROM THE 1985 TO 1988 SURVEYS BY PHILADELPHIA GAS WORKS AND PHILADELPHIA ELECTRIC COMPANY CONSISTENTLY REVEAL THAT THOUSANDS OF PROPERTIES ARE FOUND TO BE VACANT EACH YEAR! (SIMILAR RESULTS WERE FOUND BY THE PHILADELPHIA WATER DEPARTMENT IN ITS 1987 SURVEY AS WELL.) HUNDREDS OF ADDITIONAL FAMILIES WERE FOUND TO BE LIVING IN THEIR HOMES TOTALLY WITHOUT ANY SOURCE OF HEAT. AND, OF COURSE, THOUSANDS MORE WERE RELYING ON POTENTIALLY HAZARDOUS SPACE HEATERS OR HEAT FROM RANGE-TOP BURNERS.

THE NFFN BELIEVES THAT THE FURTHER EXACERBATION OF THIS DIRE SITUATION THAT WILL UNDOUBTEDLY RESULT FROM FURTHER SHRINKAGE OF FEDERAL ENERGY ASSISTANCE RESOURCES IS, SIMPLY, UNACCEPTABLE. WE IN THE PRIVATE SECTOR ARE COMMITTED TO SUSTAINING OUR PUBLIC/ PRIVATE PARTNERSHIP EFFORTS LOCALLY, TO PROVIDE NECESSARY SUPPLEMENTS TO GOVERNMENTAL FUNDING. MANY OF US HAVE HELPED ENSURE THAT STATES USED OIL OVERCHARGE FUNDS (WHICH OF COURSE ARE NOW VIRTUALLY DEPLETED), AND EVEN STATE REVENUES, SIMILARLY TO SUPPLEMENT LIHEAP DOLLARS. WE AGREE THAT AT THE LOCAL AND STATE LEVELS, WE MUST BE PARTNERS IN THE EFFORT TO PROVIDE THE NECESSARY RESOURCES TO ADDRESS EFFECTIVELY THE PERSISTENT AND COMPLEX ENERGY/POVERTY CRISIS WE FACE IN THIS COUNTRY. BUT, IF WE ARE TO PRESERVE ANY KIND OF MEANINGFUL ENERGY SAFETY NET FOR OUR MOST VULNERABLE CITIZENS, WITHDRAWAL OF THE FEDERAL GOVERNMENT AS A PARTNER IN THIS EFFORT MUST CEASE, AND INDEED, MUST BEGIN TO REVERSE ITSELF. PARTICULARLY AT A TIME WHEN THE FEDERAL TREASURY IS THE REPOSITORY OF $1 BILLION IN STRIPPER WELL FUNDS, THE FURTHER 20% REDUCTION IN FFY 1990 FUNDING PROPOSED BY THE ADMINISTRATION IS UNTHINKABLE. IN ACCORDANCE WITH RESOLUTIONS PREVIOUSLY ADOPTED

UNANIMOUSLY BY OUR MEMBERSHIP, AS WELL AS ACTION TAKEN BY OUR BOARD OF DIRECTORS, WE RESPECTFULLY BUT URGENTLY COMMEND TO YOU RESTORATION OF LIHEAP FUNDING IN FFY 1990 TO THE RANGE OF $2 BILLION, AS A MATTER OF HUMANE, FAIR AND SOUND PUBLIC POLICY.

THANK YOU FOR YOUR CAREFUL CONSIDERATION OF THIS TESTIMONY.

Senator SPECTER. Well, thank you very much, Ms. Parrish. You have many strong advocates in the Congress. I have been in the forefront of this effort year in and year out, and we will do our utmost to provide as much funding as we can in this area.

The recurrent problem, which I know all of you understand, is the problem of the budget constraint. This subcommittee has worked very long and very hard to stretch the dollars as far as we can and we have won some big fights in competition with the other subcommittees. Won a big one last year to bring extra dollars, which has enabled us to put the funding forward. We will continue to be strong advocates for these important programs.

SUBCOMMITTEE RECESS

That concludes the hearings today and the subcommittee will stand in recess until 9:30 a.m., Thursday, May 11, when we will meet in SD-116 to continue our public witness hearings on the administration's fiscal year 1990 budget request.

[Whereupon, at 12:36 p.m., Monday, May 8, the subcommittee was recessed, to reconvene at 9:30 a.m., Thursday, May 11.]

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